"Desperately banging on the door": High-Intensity Therapist's Experience of Delivering Cognitive Behavioural Therapy to Individuals with Obsessive Compulsive Disorder: A Thematic Analysis

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Abstract

Cognitive behavioural therapy (CBT) has been shown to be an effective therapeutic approach for individuals experiencing obsessive-compulsive disorder (OCD). However, significant challenges regarding client dropout from treatment have been identified within the literature. Qualitative research exploring the experiences of the clinicians delivering this form of therapy to those with OCD is lacking. This research study aimed to address this gap in the current literature base, thereby offering an opportunity for the identification of the ways in which treatment delivery may be improved in an effort to enhance client engagement.

Eleven qualified high-intensity CBT therapists holding a British Association for Behavioural and Cognitive Psychotherapies (BABCP) registration, working within the National Health Service (NHS) or private practice, participated in an audio-recorded semi-structured interview focusing on exploring their subjective experiences of delivering high-intensity CBT to individuals with a diagnosis of OCD.

The collected data was analysed using thematic analysis. Four major themes were identified in the participants' accounts. These themes were labelled 'Drowning in the Complexity'; 'Boxed In and Shut Out'; 'Desperately Seeking Control' and 'Frustrated Practice'.

Findings suggest that participants frequently felt a sense of being lost in therapy with clients, owing to the varying nature of the clients' reported intrusions and compulsions in combination with the presence of other co-morbid mental health problems. Contextual constraints, particularly within the NHS environment, in addition to the occurrence of client resistance to therapeutic techniques, appeared to result in therapists attempting to regain control of the therapeutic endeavour by adopting an overly didactic and directive approach. Such a stance appeared to have an impact on the therapeutic relationship between the therapist and client. The implications of the findings for future clinical practice regarding CBT for OCD are considered and the relevance of these findings to counselling psychology is explored. A critical review of the study is presented along with suggestions for future research.

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LIST OF ABBREVIATIONS

APA: AMERICAN PSYCHIATRIC ASSOCIATION
BABCP: BRITISH ASSOCIATION FOR BEHAVIOURAL AND COGNITIVE PSYCHOTHERAPIES
CBT: COGNITIVE BEHAVIOURAL THERAPY
DSM-V: DIAGNOSTIC AND STATISTICAL MANUAL FOR MENTAL DISORDERS: FIFTH EDITION
ERP: EXPOSURE RESPONSE PREVENTION
GAD: GENERALIZED ANXIETY DISORDER
HCPC: HEALTH AND CARE PROFESSIONS COUNCIL

IPA: INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS
NICE: NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE
OCD: OBSESSIVE COMPULSIVE DISORDER
PTSD: POST TRAUMATIC STRESS DISORDER
PMHCW: PRIMARY MENTAL HEALH CARE WORKERS
RCT: RANDOMIZED CONTROL TRIAL
WAI-SR: WORKING ALLIANCE INVENTORY-SELF REPORT
Y-BOCS: YALE-BROWN OBSESSIVE COMPULSIVE SEVERITY SCALE
SSRI: SELECTIVE SEROTONIN REUPTAKE INHIBITOR

1.0 Introduction

The diagnostic criteria for obsessive-compulsive disorder (OCD) along with its prevalence and impact will be explored before presenting the National Institute of Clinical Excellence (NICE) guidelines for the recommended treatment of OCD, which includes cognitive behavioural therapy (CBT) (NICE, 2005). The evidence base regarding the clinical effectiveness of CBT for OCD will be critiqued and issues surrounding adherence to this form of therapy will be discussed. The literature concerning client and therapist perspectives on the delivery of CBT and the therapeutic factors that may impact on clients' engagement with this form of therapy will be presented. Lastly, the importance of gaining clinicians' perspectives on the delivery of CBT for OCD will be highlighted, culminating in the presentation of the rationale and aims of the study along with the specific research question.

1.1: Literature Review

A literature review of the available evidence base relating to CBT for individuals with OCD, with a particular focus on client and therapist subjective experience of receiving and delivering CBT respectively, was explored in order to contextualize the research project. The following questions were used to guide the review:

1) How do clients experience receiving CBT for OCD?
2) How do therapists experience delivering CBT for OCD?
3) What challenges do therapists face in delivering CBT for OCD?
4) How do therapists manage the challenges encountered?

1.1.2 Search Strategy

A literature search of the electronic databases 'Academic Search Complete', 'PsychARTICLES' and 'PsychINFO' was conducted. A variety of search terms were applied including 'obsessive-compulsive disorder'; 'Therapist Experience' and 'Cognitive-Behavioural Therapy'. Please refer to Appendix 1 for the complete search strategy employed. No time-frame restriction was applied. Grey literature, conference presentations and unpublished work were also searched in order to identify relevant research articles. Abstracts were read and relevant studies identified. Studies were excluded from this review if the focus was not primarily on adult OCD (individuals

over the age of eighteen) or if an English language copy of the study was not available. References of relevant studies were searched manually in order to identify other relevant literature.

1.2 Obsessive Compulsive Disorder: Definition, Diagnosis and Prevalence

1.2.1 Definition and Diagnosis of OCD

OCD is a mental health problem characterized by intrusive and distressing thoughts or images, termed obsessions (Foa, 2010). Such obsessions can in some instances be accompanied by ritualistic and repetitive behaviours, known as compulsions, which are undertaken in an attempt to reduce obsession-related anxiety (Knopp-Hoffer, Knowles, Bower, Lovell, & Bee, 2016).

The Diagnosis and Statistical Manual for Mental Disorders (5th ed.; DSM-V; American Psychiatric Association (APA), 2013) provides clinicians with specific criteria for the diagnosis of OCD along with other mental health problems. According to the DSM-V (APA, 2013) OCD may be present when there is a presence of obsessions, compulsions or both. The definition of obsessions and compulsions, as defined by the DSM-V (APA, 2013), are outlined in Table 1:

Table 1: DSM-V definition of obsessions and compulsions (APA, 2013)

Obsessions:	***Compulsions:***
1. Recurrent and persistent thoughts, urges, or impulses that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.	*1. Repetitive behaviours (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.*
2. The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (e.g. by performing a compulsion).	*2. The behaviours or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviours or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.*

Other criteria used to assess the presence and severity of OCD include the time dedicated by the individual to obsessions or compulsions (at least one hour per day) along with the impact of such symptoms on social and occupational functioning (APA, 2013). In order for a diagnosis of OCD to be considered, the symptoms must not be attributable to any physiological cause such as a medical condition or the use of substances (recreational or prescription drugs or alcohol) or any other diagnosed mental health condition (APA, 2013).

It is acknowledged that the use of diagnostic categories within the field of counselling psychology is contentious (Larsson, Brooks & Leowenthal, 2012). Some argue that the counselling psychology profession sits in between two opposing epistemological positions. On the one hand counselling psychology embraces a positivist epistemological stance which advocates objectivity and is conducive to the use of diagnostic categorization. On the other hand, counselling psychology strongly proselytises a phenomenological epistemological position in which subjectivity of the individual is paramount. The central tension, therefore, resides around the way in which counselling psychologists maintain their humanistic value base while working in a system aligned with the medical model, resulting in diagnostic categories being the predominant language through which individuals' difficulties are viewed and discussed. In order to exist within this tension, counselling psychologists accept the use of the DSM-V (APA, 2013) but take a critical view of it, always aware of the ways in which *"the system influences our practice both for the good and the bad, implicitly and explicitly"* (Golsworthy, 2004, p.23). This critical, questioning stance will be adhered to throughout this research project.

1.2.2: Prevalence rates and impact of OCD

The lifetime prevalence of OCD in the UK is estimated to be 1.2%, with international prevalence rates reported as 1.1%-1.8% (Rachman & De Silva, 2009). Research indicates males are likely to have an earlier age of onset and a higher prevalence of hoarding and sexual obsessions and compulsions, while females are likely to have a greater occurrence of contamination and cleaning compulsions (Mahajan, Chopra, Mahajan, 2014). Research has shown that OCD can significantly affect an individual's quality of life and cause pronounced functional impairment (Koran, Thienemann,

Davenport, 1996). In particular, it was noted that those with OCD may show difficulties with family and social activities, resulting in loss of friendships, marital problems and financial issues (Sahoo, Sethy & Ram, 2017). The impact of the condition is not isolated to the individual themselves, frequently also affecting the lives of family and friends (Fontenelle et al., 2010). OCD is known to be a chronic condition which without treatment is unlikely to improve (Kohn, Saxena, Levav & Saraceno, 2004).

1.3 Therapeutic Interventions for OCD

Historically, mental health professionals viewed OCD as an untreatable and intractable mental health difficulty due to little benefit being gained from the delivery of traditional psychoanalytic therapy to clients diagnosed with the condition (Foa, 2010). However, significant advances have been made in the treatment of OCD, as discussed below.

1.3.1 Psychoanalysis

Until the 1960's, psychoanalysis and psychodynamic theories of OCD, influenced heavily by the work of Freud (1955), were viewed as the best conceptualisation of this difficulty (National Collaborating Centre for Mental Health, 2006). Freud theorized that obsessional phenomena were a consequence of anxiety resulting from unresolved Oedipal conflicts with treatment focusing on the identification and alteration of defence mechanisms that maintain the anxiety (Salzman, 1983). However, evidence for the effectiveness of such an approach is insufficient, and research appears to be limited to single-case reports and theoretical reviews (Foa, 2010). Current NICE guidelines do not recommend psychoanalysis as a viable treatment approach for OCD (NICE, 2005). Recent investigations regarding short-term psychodynamic therapeutic approaches for OCD have been undertaken; however, such an approach is yet to be critiqued through the means of a randomized control trial (RCT) (Leichsenring & Steinert, 2016).

1.3.2 Behavioural Therapy

Early behavioural therapy for OCD involved the use of operant-conditioning procedures focusing on the 'punishment' of obsessions and compulsions, in the hope that when the specific behaviour was paired with an unpleasant event the described behaviour would become extinguished (Foa, 2010). Such an approach, however, had limited success for those with OCD (Lam & Steketee, 2001). Subsequently, the work of Meyer (1966) resulted in the development of a behavioural therapy for OCD known as Exposure and

Response Prevention therapy (ERP) (Foa, 2010). ERP involves asking clients to confront feared situations that trigger obsessive thoughts (exposure) and refrain from carrying out compulsions (response prevention) until the anxiety naturally subsides through a process of habituation (Maher, Wang, Zuckoff, Wall, Franklin Foa & Simpson, 2012). Such exposure may take place *in-vivo* (i.e. in real life) in which the client will be asked to confront cues, such as specific situations, words or images that trigger obsessive thoughts. Alternatively, imaginal exposure may be conducted in which the client is asked to describe and imagine in-detail the situations triggering obsessions (Foa, 2010).

1.3.3 Cognitive Therapy

Cognitive therapy (CT) for OCD aims to identify and alter specific cognitive distortions that may be acting to maintain anxiety and compulsive behaviour. A key cognitive distortion present in those with OCD is a heightened sense of responsibility for preventing harm (Salkovskis, Shafran, Rachman & Freeston, 1999). This can be accompanied by 'thought-action fusion' which is a fear that experiencing a thought may result in this thought becoming reality (Veale, 2007). CT involves verbally challenging these cognitive distortions in addition to completing behavioural experiments designed to activate and then disconfirm the unhelpful beliefs (McKay, Sookman, Neziroglu, Wilhelm, Stein, Kyrios, Matthews & Veale, 2015).

1.3.4 Cognitive-Behaviour Therapy and psychopharmacology

Treatment for OCD can involve combining ERP and CT approaches (Ost, Havnen, Hansen & Kvale, 2015). Within this research project, as is the case within the literature base, the term CBT is used to reflect treatment protocols integrating exposure-based treatment with cognitive therapy approaches (McKay et al., 2015). CBT for OCD can involve psycho-education, formulation, cognitive strategies and ERP techniques (Olatunji, Davis, Powers, & Smits, 2013). Psychiatric medication can be used in the treatment of OCD either as a stand-alone treatment or combined with psychological therapy (NICE, 2005). Several studies have indicated that selective serotonin re-uptake inhibitors (SSRI's) may be beneficial in reducing symptoms of OCD (Goodman, Kozak, Liebowitz & White, 1996).

1.3.5: NICE Guidelines: High-Intensity and Low-Intensity CBT

In terms of current clinical practice, psychologists and cognitive behaviour therapists are required to follow the guidelines outlined by NICE. NICE currently recommends that CBT, including ERP, can be provided to those experiencing OCD (NICE, 2005). Treatment is divided into low-intensity and high-intensity options, which are assigned based on the individual's level of functional impairment (NICE, 2005).

Adults with mild OCD may be offered low-intensity psychological treatment consisting of either brief individual CBT (including ERP) based on structured guided self-help materials, brief individual telephone-based CBT (including ERP), or group CBT (including ERP). Low-intensity interventions are all characterized by ten hours or less of therapist contact per patient (NICE, 2005). Adults with moderate functional impairment may be offered a choice of psychopharmacological treatment or a course of high-intensity individual CBT (including ERP), consisting of ten hours or more of therapist contact per patient (NICE, 2005). Those with severe functional impairment can be offered a combination of high-intensity psychological treatment and a course of psychopharmacological treatment (NICE, 2005). Those who deliver high-intensity CBT are known as 'High-Intensity Therapists' meaning they are qualified CBT therapists or psychologists registered with the BABCP.

1.3.6 CBT Delivery: Treatment Contexts

CBT treatment can be delivered within NHS settings, and clients with OCD are most commonly referred to Improving Access to Psychological Therapy (IAPT) services. Within the United Kingdom (UK) introduction of the IAPT programme in 2008 has enabled a substantial increase in the number of people receiving evidence-based NICE-recommended treatment for common mental health problems (NHS England, 2016). A recent report outlining a five-year plan for mental health care in the UK committed to expanding the IAPT programme to enable over 25% of the population to access evidence-based psychological therapy (NHS England, 2016). Treatment delivered in IAPT is short-term, with the maximum permissible number of sessions limited to twenty (Marzillier & Hall, 2009). CBT treatment can also be delivered to clients in private therapy, involving fewer time limits regarding number and length of sessions.

1.4: Clinical effectiveness of CBT for OCD

Meta-analyses comparing the effect sizes resulting from ERP and CT alone and in combination have been conducted (Rosa-Alcazar, Sanchez-Meca, Gomez-Conesa & Marin-Martinez, 2008; Olatunji et al., 2013; Ost, Havnen, Hansen, & Kvale, 2015). A meta-analysis of nineteen empirical studies, all of which possessed a control group (waiting list and/or placebo), indicated similar effect sizes for ERP and CT alone. The combination of ERP and CT proved highly effective (Rosa-Alcazar et al., 2008). A significant limitation of this analysis, however, was that the effect size for CT alone was produced from only three studies (Rosa-Alcazar et al., 2008). Furthermore, one of the major challenges regarding meta-analysis of this subject area is the variation in different clinical outcome measures used across different empirical studies. Therefore, in order to eliminate the potential bias in the calculated effect size arising from the comparison of different outcome measures, a more recent meta-analysis (Ost et al., 2015) applied an inclusion criteria of the use of the clinician-administered Yale-Brown Obsessive Compulsive Severity Scale (Y-BOCS)[1] (Goodman et al., 1989) as the outcome measure for all RCT's included in the review. 37 RCTs published between 1993-2014 were included. This meta-analysis supports the findings of previous analyses (Olatunji et al., 2013; Rosa-Alcazar et al., 2008) in finding ERP and CT alone similarly effective treatments for OCD.

1.5 Critique of the CBT Model

The short-term nature of CBT interventions, based on structured protocols, lends itself to empirical investigation resulting in a large evidence base espousing the clinical effectiveness of this approach across a range of different mental health conditions and clinical populations (Gaudiano, 2008). Owing to this evidence base, guidelines for treatment frequently recommend the use of CBT for the treatment of a range of different mental health problems (Gaudiano, 2008). However, opponents of CBT have reported that *"most CBT trials are small and poorly executed; quality thresholds for RCT's in NICE guidelines are notoriously low, allowing meta-analyses of small poor-quality studies to direct policy"* (Richards, 2007). Furthermore, whilst CBT use within the NHS is widespread, some have highlighted its potential limitations, with opponents of the model describing it as overly mechanistic, preventing a holistic view of the clients and

[1] Y-BOCS refers to the scale used in research and clinical practice to determine the presence and severity of OCD symptoms (Goodman et al., 1989).

their difficulties (Gaudiano, 2008). The model has been criticised for its limited exploration of childhood experiences and the impact of these on psychological functioning (Ryle, 2012). Furthermore, CBT assumes that the client is able to form a collaborative relationship with the therapist, and the therapeutic relationship itself is not typically a focus of the intervention (Westbrook, Kennerley & Kirk, 2011). When difficulties arise in the relationship, these are viewed as obstacles to be overcome in order to obtain the client's compliance with the CBT techniques, while the interpersonal issues arising in the relationship remain unaddressed (Young, Klosko & Weishaar, 2003).

1.6 Client refusal and non-compliance with CBT for OCD

While recent meta-analyses suggest that ERP, CT and the combination of these techniques are clinically effective, issues surrounding non-response to treatment, treatment refusal and dropout rates remain major concerns (Ost et al., 2015). An investigation indicated a 31% dropout rate from CBT for OCD (Mancebo, Eisen, Sibrava, Dyck & Rasmussen, 2011). A more recent meta-analysis of thirty-seven studies reported that 15% of eligible patients refused treatment (Ost et al., 2015). It was noted that "*RCT's usually do not specify the reasons for declining participation"* (Ost et al., 2015, p.168), warranting further investigation into possible contributory factors. In addition to a high refusal rate, Ost et al. (2015) found a mean dropout rate of 15% across the studies included in the review. This varied according to the form of treatment, the ERP/CT combination therapy and antidepressant treatment format showing the highest dropout rate at 32%. Overall, these findings suggest that while CBT is clinically effective, difficulties remain with patients initiating and completing treatment and these remain largely un-researched from a client or clinician perspective.

The studies highlighted above provide a quantitative measure of clinical effectiveness of CBT for OCD through the use of standardised outcome measures, in addition to the overall dropout rates within RCT studies. However, these investigations do not provide an understanding of the way in which specific therapeutic factors (i.e. factors fundamental to a particular therapeutic approach) and non-specific therapeutic factors (factors common to all therapeutic approaches such as the therapeutic alliance) (Clarke, Reese, Hardy, 2004) may impact on treatment from the perspective of either client or

therapist. Furthermore, these investigations cannot provide information on the potential impact of these therapeutic factors on dropout rates.

1.7 The role of specific and non-specific factors in CBT for OCD

A significant debate exists within the literature regarding the mechanisms that can account for the effectiveness of psychological therapy (Huibers & Cuijpers, 2015). Some argue it is specific therapeutic factors unique to the various forms of psychotherapies that are responsible for the changes seen in therapeutic interventions (Huibers & Cuijpers, 2015). In contrast, proponents of the 'common factors model' claim that it is those factors that are common to all forms of psychotherapy (i.e. non-specific therapeutic factors), which are central to treatment effectiveness (Wampold & Imel, 2015).

Four non-specific factors have been identified as being present in most clinically effective psychotherapies:

(a) A strong therapeutic relationship:
(b) A healing setting;
(c) A rationale for treatment providing a credible explanation for the client's symptoms
(d) A treatment procedure (Frank & Frank, 1991).

Treatment procedure' is considered a non-specific factor to the extent that the application of any psychological therapy treatment procedure, regardless of its content, is used across different therapies (Ilardi & Craighead, 1994). These non-specific factors have been shown to potentially have an impact on treatment effectiveness through mechanisms such as client re-moralization (Frank & Frank, 1991), increased client positive expectancies (Lick & Bootzin, 1975) and enhanced client self-efficacy (Bandura, 1977). In particular, a non-judgemental and supportive context, along with the opportunity to make sense of their experiences, have been identified by those with OCD who have received CBT as being important aspects of the treatment in terms of enabling them to overcome their trepidation with discussing their intrusive thoughts, and have aided increasing their motivation to engage in therapy (Marsden, Teaham, Lovell, Blore & Delgadillo, 2018).

Research exploring clients' perspectives on the helpful aspects of CBT for depression indicated that they valued both specific and non-specific therapeutic factors (Clarke et al., 2004). The specific therapeutic factors highlighted by these participants included the use of the CBT model to understand the relationship between thoughts, feelings, physical sensations and behaviour; the use of thought-challenging techniques; identification of core beliefs; and engaging in behavioural experiments (Clarke et al., 2004). Non-specific factors that appeared important to the participants were the holding and containing environment provided by the therapist, feeling understood, provision of a safe environment and the collaborative relationship between therapist and participant (Clarke et al., 2004).

Within CBT for OCD, the specific therapeutic factors purported to be important in clinical outcomes are cognitive techniques such as challenging clients' perceptions of the meaning of intrusive thoughts, and psycho-education to normalize the presence of intrusive thoughts (Fama & Wilhelm, 2005), along with the behavioural technique of ERP (Abramowitz, 1997). The effectiveness of these specific factors, in terms of outcome measures, has been highlighted through meta-analysis of RCT's (Ost et al., 2015). A recent investigation attempting to disentangle the proportion of improvement in symptom severity for OCD related to the specific factor of ERP indicated that ERP was responsible for 68% of reduction in symptom severity, with the remaining 32% accounted for by 'other factors', suggesting some role for non-specific factors, such as the therapeutic relationship, in clinical improvement of OCD symptoms (Strauss, Huppert, Simpson & Foa, 2018). Further to ERP and cognitive techniques, a specific therapeutic factor that may be important in CBT for OCD is the use of motivational interviewing (MI) techniques (Miller & Rollnick, 1991). While MI is not currently incorporated into standard CBT protocols for OCD, it has recently been highlighted as a potential mechanism of enhancing client engagement (Simpson, Zuckoff, Maher, Page, Franklin, Foa, Schmidt & Wang, 2010). ERP presents a significant challenge to clients due to difficulties with remaining in a feared situation without engaging in rituals (Simpson et al., 2010). Research has indicated that when MI techniques are incorporated into the treatment there is an improved uptake of ERP (Maltby & Tolin, 2005). However, the combination of MI into the standard CBT protocol for OCD has

produced mixed outcomes (Simpson, Zuckoff, Page, Franklin & Foa, 2008; Simpson et al., 2010).

The potential importance of non-specific factors related to the role of the therapist within CBT for OCD, is indicated through the apparent difference in the effectiveness of ERP according to the degree of therapist involvement in this technique. The ERP component of CBT treatment can be conducted in a variety of different ways, each with varying degrees of therapist contribution. The 'classic' form of ERP therapy can be referred to as '*therapist-directed/therapist-conducted',* in which the therapist devises a graded hierarchy with the client and accompanies the client when these ERP tasks are being completed. On the opposite end of the spectrum, a purely '*self-directed/self-conducted'* ERP treatment involves the client devising their own hierarchy and completing the exposure tasks without the assistance of a therapist. In those receiving *'therapist-directed/therapist-conducted'* ERP, 66.7% achieved clinically significant change, compared to only 22.7% in '*self-directed/self-conducted'* cases (Jacobson & Truax, 1991). In between these two ends of the continuum is *'therapist-directed/self-conducted'* ERP, in which the therapist provides psycho-education regarding OCD, the rationale for conducting ERP, aids the creation of the exposure hierarchy and elicits feedback from the client once exposure tasks have been completed without the therapist being physically present during the tasks. Analysis of the effectiveness of *'therapist-directed/therapist-conducted'* versus '*therapist directed/self-conducted'* ERP demonstrated that as the degree of therapist contact reduces so does the benefit the client derives from the intervention (Greist, Marks, Baer, Kobak, Wenzel, Hirsch et al., 2002). Overall, these findings suggest an important role for the therapist in the success of ERP, since those receiving the same intervention but through a self-help format do not experience the same levels of effectiveness (Kozak & Coles, 2005). Therefore, the therapist may be able to add variables beyond the actual therapeutic technique (Kozak & Coles, 2005).

A means by which the therapist may contribute to the treatment beyond the specific therapeutic techniques may be through the use of the therapeutic relationship. The strength of this relationship is known to be an important predictor of outcome in psychotherapy research regardless of the therapeutic modality (Roth & Fongay, 1996; Horvath & Symonds, 1991). Research has demonstrated the importance of the

therapeutic relationship as a predictor of treatment outcome in CBT specifically for clients with OCD (Vogel, Hansen, Stiles & Gotestam, 2006; Keely, Storch, Merlo & Geffken, 2008). While the relationship is not viewed as the main focus of CBT (Gilbert & Leahy, 2007), an awareness of its importance is vital when overcoming challenges. Given that the therapeutic relationship is an independent predictor of outcome in CBT for OCD (Vogel et al., 2006) the degree to which the therapist is fostering and developing this relationship in clinical practice is important to elucidate.

Within the last ten years there has been an increasing interest in the role of the therapeutic relationship in the context of cognitive therapy (Leahy, 2008; Cartwright, 2011; Cartwright, Rhodes, King and Shires, 2014). Indeed research has indicated that a CBT therapist's capacity to become aware of and constructively utilise the interpersonal dynamics and processes that are occurring in the therapeutic relationship is an important element of successful treatment outcomes (Safran & Segal, 1996). The terms transference and counter-transference were originally developed within psychodynamic paradigms, however these concepts have now acquired a trans-theoretical status and the consideration of the importance of such ideas has begun within the domain of cognitive therapy (Cartwright et al, 2014). Reflection on these traditionally psychodynamic notions may enable cognitive therapists to avoid becoming entangled in potentially negative and therapy interfering behaviours (Leahy, 2001; Cartwright, 2011) as research has indicated that counter-transference enactments can negatively impact on therapy outcomes (Hays, Gelso and Hummel, 2011). Within a cognitive framework transference can be understood as the "*clients responses to the therapist and to therapy, which are manifestations of the clients core beliefs, schemas of self and others, and relationship schemas, developed as a result of formative experiences in relationships with significant others"* (Cartwright, 2011, p.115). Whilst a CBT therapist would not be expected to work with the clients transference is the manner that a psychodynamic therapist would adopt, it has been argued that the exploration of the transference responses of the client within the therapeutic relationship can aid the formulation and understanding of the clients presenting problems (Newman, 2013). Within psychodynamic theory, counter-transference can be defined as the unconscious projections of the therapist onto the client based on unresolved developmental conflicts (Storr, 1989). However, CBT rejects the notion of the unconscious and therefore counter-transference is given a broader definition in this context, defined as *"the therapist's cognitive, emotional and*

behavioural reactions to the patient, which are conscious and accessible to the therapist" (Haarhoff, 2006, p.127). Counter-transference can be divided into subjective counter-transference, referring to the therapist's emotional responses to the client based on the therapist's own core beliefs, schema, assumptions and standards (Cartwright, 2011) and objective counter-transference, referring to the therapist's response to the transference of the client and the client's perceptions, affects and way of relating. According to the concept of objective counter-transference *"a client's maladaptive way of relating to the therapist provokes responses in the therapist that are similar to the responses of others in the client's life"* (Cartwright, 2011, p.115). In this way, the client exhibits certain 'pulls' on the therapist and elicits reactions from them. Therapists with a good understanding of, and attunement to, counter-transference resist the desire to act in a manner expected by the client, instead reflecting on what is generating these emotional reactions in the therapist in order to better understand the client's way of relating (Cartwright, 2011). Empirical studies support the notion of objective transference. For example, Betan, Heim, Conklin & Westen (2005) explored the counter-transference response of 181 psychologists and determined eight counter-transference patterns that corresponded to specific client groups and mental health problems in a predictable fashion. A significant correlation was found between the therapist's counter-transference responses and the client's specific diagnosis of personality disorder, such that clinicians consistently responded to this client group with an overwhelmed/disorganised counter-transference pattern. In essence, attending to the objective counter-transference provides an opportunity for the therapist to gain insight into the emotional responses the clients trigger in others as a result of their maladaptive relationship beliefs and behaviours (Cartwright et al., 2014). However, while subjective counter-transference is more commonly accepted and reflected on within cognitive therapy, objective counter-transference has not received the same attention amongst those practicing CBT (Cartwright, 2011). Incorporating a space for therapists to additionally reflect on their objective counter-transference experiences, may prevent negative therapy-interfering consequences from arising (Cartwright, 2011).

In summary, CBT is known to be a clinically effective treatment for OCD; however, a significant dropout rate has been reported (Ost et al., 2015) for which RCT's have provided little information or explanation (Ost et al., 2015). In addition, the client's and therapist's subjective perception of the ways in which specific and non-specific

therapeutic factors impact on adherence and engagement with this model of treatment, cannot be elucidated by these quantitative investigations of clinical effectiveness. Therefore, a fuller understanding is needed, through further research, of both client and therapist experience of receiving and delivering CBT for OCD, with the aim of better conceptualising the ways in which specific and non-specific therapeutic factors may impact on adherence and engagement with treatment. A review of the current research regarding this topic area is presented below.

1.8 Client Experience of Receiving CBT for OCD

In order to understand issues surrounding adherence and engagement with CBT for OCD it is necessary to consider the perspective of the individual receiving the treatment (i.e. the client), the perspective of the individual delivering the treatment (i.e. the therapist) and the interactions between these two parties. Research to date has focused almost entirely on the experience of the client, which will now be evaluated and critiqued.

Quantitative studies attempting to elucidate levels of client satisfaction with receiving ERP as a standalone treatment (Tolin, Diefenbach & Gilliam, 2011) or combined ERP and CT treatment (Jonsson, Hougaard & Bennedsen, 2011) have been conducted using quantitative research instruments, including client satisfaction Likert scales and patient evaluation questionnaires. These studies show that clients appear satisfied with their CBT treatment (Tolin et al., 2011; Jonsson et al., 2011). However, generic measures of client satisfaction do not provide information regarding the specific or the non-specific therapeutic factors, such as aspects of the therapeutic alliance, which may have contributed to the overall reported client acceptability and satisfaction. Therefore, quantitative investigations such as this are limited because an understanding of the process through which client satisfaction is generated cannot be gleaned from this data. As such little can be ascertained about areas in which improvements could be made to reduce client drop-out rates.

Targeted quantitative research regarding clients' perspectives on reasons for dropout from CBT for OCD has been conducted (Mancebo et al., 2011). It has been hypothesised that a key contributing factor towards high patient refusal and attrition rates may be patient concerns and fear about completing exposure work or inaccurate

patient expectations regarding CBT treatment for OCD (Kozak & Coles, 2005; Tolin & Hannan, 2005). A longitudinal observational study of 202 individuals with a primary diagnosis of OCD explored the clients' specific reasons for under-utilization of CBT for OCD (Mancebo et al., 2008). Within this study a 31% dropout rate was identified. A quantitative questionnaire, the 'Treatment Adherence Survey-Patient Version', was used to assess self-reported reasons for CBT dropout. One quarter of the self-identified CBT dropouts endorsed 'fear/anxiety regarding engaging in ERP' as a reason for terminating treatment. Of the participants endorsing this reason, the majority indicated it was the primary factor in their decision to disengage. These findings offer support to the notion that the fear of engaging in exposure is a key area of concern for clients attempting to engage in CBT (Mancebo et al., 2011). Whilst this study provides deeper insight into aspects of treatment which may impact on client engagement, the quantitative nature of the investigation, using a questionnaire asking participants to endorse pre-defined items on a list of possible reasons for non-engagement, restricts an in-depth understanding of the individual participants' unique experience told in their own words. Moreover, the self-report measure may have led participants to answer in a fashion that they believed was socially desirable, thereby influencing the findings.

Further to the above research, investigations have been conducted to ascertain the relationship between patient adherence and the quality of the therapeutic alliance as perceived by the client. Twenty-eight participants were asked to complete the quantitative 'Patient Exposure and Response Prevention Adherence Scale' in order to ascertain the frequency and the quality of between-session exposure tasks (Maher, Wang, Zuckoff, Wall, Franklin, Foa & Simpson, 2012). In addition, participants completed the Working Alliance Inventory-Self-Report (WAI-SR) (Halperin, Weitzman & Otto, 2010) which aims to assess degree of positive personal attachment, participants' trust in their therapist, patient attitudes regarding ERP and the extent to which the client and therapist agree on the goals developed for treatment. Results from the study showed that therapeutic alliance (as measured by the WAI-SR) had a significant independent effect on patient adherence, suggesting that therapists, by ensuring they have a good understanding of the clients' difficulties and properly explaining the goals for treatment and the strategies to be used, can have an impact on treatment adherence (Maher et al., 2012). It was also determined that patient adherence to ERP had a significant effect on overall treatment outcome, concurring with findings from previous research (Simpson,

Maher, Wang, Boa, Foa & Franklin, 2011). While this study highlights the importance of the therapeutic alliance on client adherence to ERP elements of treatment, the quantitative nature of the investigation limits the depth of information gained from participants, frustrating investigation of their subjective experience due to participants being asked to rate items on a Likert scale, with no space for expansion on their individual perspective.

Overall, the above research provides more information, beyond studies purely investigating clinical effectiveness, regarding clients' specific concerns related to engaging with CBT and the importance of the non-specific factor of the therapeutic alliance. Qualitative research regarding clients' subjective experiences can add to quantitative investigations in order to improve understanding of the means by which therapeutic factors are a help or hindrance in facilitating adherence (Clarke et al., 2004). Within the literature there is limited qualitative exploration of client experience of receiving individual CBT treatment for OCD. Three relevant studies were identified, however, which will now be briefly critiqued and discussed.

A recent qualitative study conducted within an IAPT service explored the perspectives of thirty-six adults with a diagnosis of OCD regarding the acceptability of receiving one of two possible low-intensity CBT interventions (computerised CBT or guided self-help) (Knopp-Hoffer et al., 2016). The data was analysed using thematic analysis with the identified themes indicating several non-specific therapeutic factors as important within the client experience. Therapist support was identified as a major theme, its two main benefits appearing to be the motivating impact provided by the therapist and the rapport established between therapist and client. Participants also reported face-to-face support as necessary to prevent avoidance of intrusions and related embarrassment and shame (Knopp-Hoffer et al., 2016). This finding is supported by a further qualitative study which aimed to examine the perspectives and experiences of twelve participants who had received either daily intensive face-to-face support or alternatively a weekly face-to-face CBT treatment (Bevan, Oldfield & Salkovskis, 2010). The strength of the therapeutic alliance was noted as a subtheme in terms of components of this relationship, including feeling understood and supported, being helpful to clients when needing to tolerate anxiety and complete homework tasks. A further qualitative study of client experience of CBT for OCD lends support to these findings. Ten participants

were interviewed following completion of a course of CBT for OCD. A thematic analysis was conducted indicating that the client's perception of the therapist as non-judgmental and understanding facilitated their ability to disclose difficult intrusive thoughts (Marsden, Tehan, Lovell, Blore & Delgadillo, 2018). These qualitative findings concur with quantitative research highlighting the importance of the therapeutic alliance in facilitating adherence to CBT for OCD (Maher et al., 2012).

An additional non-specific factor emerging within the qualitative studies was client expectations of treatment. Knopp-Hoffer et al. (2016) reported that clients held reservations regarding change and fear of the 'new self' following CBT treatment. This finding is supported by Bevan et al. (2010) who demonstrated that client expectations impacted on treatment. This finding concurs with quantitative research suggesting that client expectations regarding the perceived lack of utility of CBT have been shown to play a role in reasons for refusal of, or drop-out from, treatment (Mancebo et al., 2011). These findings highlight a need for awareness of client expectations before treatment and an increased need for therapist support in this client group in order to appease fears and manage client perceptions of the treatment modality (Mancebo et al., 2011).

Personalisation and relevance of therapy materials also emerged as an additional factor in maintaining engagement in CBT therapy within the qualitative studies conducted (Knopp-Hoffer et al., 2016; Bevan et al., 2010), in which relevance of the therapy to the particular individual was noted as an important influence on treatment outcome, motivation and engagement and may have impacted upon treatment credibility (Bevan et al., 2010). These findings lend support to the concept of a credible treatment rationale being an important non-specific therapeutic factor (Frank, 1991). Furthermore, as OCD is known to be a heterogeneous disorder with a wide range of intrusions and compulsions (Knopp-Hoffer et al., 2016) the need for the individualisation of generic therapy materials may be particularly important with these clients. In support of these findings, Marsden et al. (2018) reported that a key difficulty faced by clients receiving CBT for OCD was that the perceived overly structured approach of the therapy inhibited their ability to fully express themselves, their idiosyncrasies and their personal circumstances.

These qualitative investigations offer some important findings related to the significance of non-specific factors from the perspective of the client, and provide a greater level of insight into client perspectives beyond the information gained from quantitative inquiry. However, a key limitation identified within each of the studies discussed was a lack of researcher self-reflexivity, which may have impacted on the findings. The potential bias and assumptions of the researchers, particularly during the process of data collection and data interpretation, did not appear to have been fully explored in these qualitative investigations, resulting in the reader being unable to ascertain the potential impact of the biases and assumptions of the researcher on the presented themes and sub-themes. Furthermore, investigations conducted by Knopp-Hoffer et al. (2016) and Marsden et al. (2018) lacked transparency on the researchers' epistemological position.

While limitations are present in these qualitative studies, the importance of the therapist emerged as a central theme within all studies, highlighting the important role of the therapist in motivating the client to engage, personalising materials to the individuals' specific difficulties, and encouraging disclosure of intrusive thoughts. In summary, central to any modality of therapeutic work is the therapeutic alliance between psychologist and client (Martin, Garske, Davis, 2000). CBT for OCD involves inducing anxiety through exposure which may be difficult for the client to tolerate or agree to, suggesting that the strength of the therapeutic alliance may be a vital factor in the success of CBT treatment for OCD (McKay, Arocho & Brand, 2014).

In summary, to date both quantitative and qualitative research has been conducted investigating client experience of CBT for OCD leading to insights from the client perspective regarding both specific and non-specific therapeutic factors that relate to compliance with treatment. The importance of the therapist regarding engagement has been highlighted. Within the research base there has been extremely limited qualitative investigation and understanding of the experience of delivering CBT to clients for any condition from the perspective of the clinician (Hassan, Bennett & Serfaty, 2017). Specifically, there has been a dearth of research attempting to elucidate practitioners' perceptions and experience of delivering CBT to clients with OCD, and in particular gaining their views on some of the challenges they encounter and how they manage these in their practice.

1.9 Clinicians' Experience of Delivering CBT for OCD

The American Psychological Association produced an initiative allowing clinicians to provide their clinical observations and feedback on empirically supported treatments for generalized anxiety disorder (GAD) (Szkodny, Newman & Goldfried, 2014); social anxiety (McAleavey, Castonguay & Goldfried, 2014) and panic disorder (Wolf & Goldfried, 2013). This initiative followed acknowledgement that there is often a unidirectional flow of information from researchers to clinicians in the form of RCT's while the views of those actually delivering therapy are not solicited or heard. Therefore, online surveys were produced allowing clinicians to report their experiences to researchers in order that a *"two-way bridge between research and practice"* was established (Wolf & Goldfried, 2013, p.7). This initiative was recently extended to include gaining feedback on delivery of psychological treatment for OCD which represents the only study to date that has been conducted using a quantitative methodology to investigate clinician experiences of delivering CBT for OCD, the findings of which will now be explored and critiqued.

An online questionnaire was devised and completed by a total of 181 clinicians (Jacobson, Newman & Goldfried, 2016). The survey attempted to elicit responses to a list of items regarding techniques used in assessment and CBT treatment along with potential barriers to treatment progress and factors that may limit the success of effective CBT for OCD. The clinicians were also asked to rate the frequency of the occurrence of each potential limitation. Results indicated that clinicians used both CT and ERP interventions in their practice in line with recommended treatment (NICE, 2005). Additionally, over 50% of the participants reported using mindfulness or acceptance and commitment (ACT) based strategies, which are not well-established treatments for OCD (Twohig, Hayes, Plumb, Pruitt, Collins, Hazlett-Stevens & Woidneck, 2010). Over half of respondents incorporated motivational enhancement techniques into their OCD practice. With regard to the specific ERP techniques used the majority of the clinicians endorsed *'therapist-directed/self-conducted'* ERP that counters research indicating that *'therapist-directed/therapist-conducted'* is most effective (Abramowitz, 1996). In terms of the barriers to treatment related to the model over 45% of the sample identified the inability of the CBT model to deal with co-morbid mental health issues as the main barrier. In addition, difficulties stimulating

anxiety-provoking situations in the session along with a lack of focus on emotional regulation were also reported as significant limits of the CBT protocol for OCD. In terms of barriers related to the client, clinicians reported the client's inability to complete between-session homework, a lack of motivation, fear of exposure and client perfectionism as limiting progress in treatment. Problems with the strength of the alliance and the clinician's own negative feelings and frustration with client progress were also endorsed as features that therapists perceived as interfering with treatment effectiveness. Lastly, reinforcement of symptoms from family and friends was supported by 80% of the sample as a reason for ineffective treatment (Jacobson et al., 2016).

This study provides important insights into the experience of clinicians themselves of the delivery of CBT for OCD and the factors that clinicians perceive to be important in delivering successful treatment. However, the quantitative nature of the study and the 'yes/no' format of the questions asked does not allow for an in-depth understanding of the therapists' subjective experience of delivering this treatment to be elucidated or provide details on how the identified challenges were managed and overcome. Although the study assessed how frequently challenges were encountered, the Likert scale employed was not able to identify the perceived impact of each of the barriers such that, whilst a particular barrier may have occurred infrequently, it may have had a greater impact on treatment than a barrier that occurred more frequently (e.g. psychosis may occur rarely but may significantly interfere with treatment). Furthermore, the online survey design of the study, in which pre-prepared items were listed for therapists to endorse or not may have been leading and suggestive. An open question format in which clinicians speak from their own experience may be more appropriate. Despite the limitations, this study gives voice to clinicians and can be used as a starting point to guide further research.

1.10 Qualitative Analysis of Clinicians' Experience of Delivering CBT for OCD

To date only one qualitative study examining the perspectives and experiences of clinicians delivering solely CBT for OCD has been conducted (Gellatly, Pedley, Molloy, Butler, Lovell, & Bee, 2017). Twenty psychological wellbeing practitioners, who delivered two forms of low-intensity CBT, namely computerised CBT (cCBT) or

guided self-help (GSH), were interviewed about their experiences of the acceptability of delivering these interventions and their perspectives on factors influencing client engagement and outcomes. The data was analysed using thematic analysis. Six main themes relating to patient and professional matters were identified. A key theme was the need to tailor the intervention to the client's needs and expectations. This finding tallies with the client perspective studies indicating that awareness of the heterogeneity of OCD and the adaptation of the therapeutic materials accordingly impacted on patient acceptability of the treatment (Knopp-Hoffer et al., 2016; Marsden et al., 2018; Bevan et al., 2010). With regards to encouraging engagement, clinicians identified the need to project service credibility, which they felt was achieved by using structured low-intensity interventions (Gellatly et al., 2017). This appears to counter previously highlighted qualitative research in which clients perceived the structured nature of the intervention as limiting their freedom of expression resulting in dropout (Marsden et al., 2018). Participants raised issues relating to their confidence in delivering treatment to clients with OCD as it was perceived by many practitioners to be a 'complex' condition and the necessity of supervision and training was highlighted. In addition, due to the time-limited nature of low-intensity interventions, issues relating to the length of contact with clients and the impact of this on the therapeutic relationship were indicated (Gellatly et al., 2017).

The findings of this study indicate themes related to personal, patient and service specific issues and provide a greater depth of understanding regarding specific and non-specific therapeutic factors involved in the delivery of CBT for OCD from the perspective of the clinician. However, the investigation was focused upon delivery of low-intensity CBT interventions, which are not the most commonly used form of CBT delivery for clients with OCD and involve only minimal therapist involvement (Gellatly et al., 2017). In addition, low-intensity clinicians will be assigned clients with only mild functional impairment. The experience of a clinician working with a client with moderate to severe functional impairment over a longer time frame may differ. Furthermore, the clinicians interviewed were psychological wellbeing practitioners and not qualified psychologists or CBT therapists. This may have had an impact on the findings due to the reduced experience in general of these practitioners, in addition to a lack of time to form and maintain a therapeutic relationship with their clients. The study was also limited in terms of a lack of reflexivity regarding the influence of the

researcher on the data collected. The individual conducting the interview was a psychological wellbeing practitioner, however, there appears to be minimal reflection or self-reflexivity on how this may have influenced the data collection process. For example, the interviewer may have attended to areas of the interviewee's experience that resonated with their own clinical experience of delivering low-intensity CBT for OCD, which may have shaped the data collected. Furthermore, with regards to data collection, semi-structured interviews were conducted over the telephone. The use of the telephone as opposed to face-to-face interviews could have led to a reduction in the richness of the data due to a loss of body language and non-verbal cues. To date there have been no investigations into the experience of qualified CBT therapists delivering NICE recommended high-intensity CBT for OCD, which is the most commonly used approach within NHS services (Gellatly et al., 2017; Lovell et al., 2017).

1.11 Research question and rationale

1.11.1 Rationale

Literature to date clearly demonstrates that CBT is an effective form of treatment for OCD. However, there are significant concerns regarding treatment dropout. From both a client and therapist perspective there appear to be certain specific and non-specific therapeutic factors, such as the therapeutic relationship, that are of importance in CBT treatment for OCD and can impact on client satisfaction, acceptability of treatment and engagement. However, a gap in the literature is apparent as clinicians' experience of delivering the most common format of therapy offered to those with OCD, namely high-intensity CBT (Knopp-Hoffer et al., 2016), has yet to be investigated. Hence, the challenges associated with the delivery of this format of treatment to those with OCD and the clinicians perceptions of the specific and non-specific factors that may be related to engagement and adherence to this treatment, are currently unknown.

Through investigating clinicians' perspectives, we may allow their voices to be heard and this information may be used to enhance CBT delivery and effectiveness. We may gain deeper insight into the perceived benefits and limitations of CBT for OCD within both NHS and private therapy contexts. The contribution of the views of practitioners can enhance the clinical effectiveness of empirically supported interventions. McCabe and Antony (2005) acknowledge that gaining practitioner feedback on an intervention

can *"improve our current treatments and further our understanding of the mechanisms underlying suboptimal response and relapse following treatment"* (McCabe & Antony, 2005, p.2). Understanding from a practitioner how they experience high-intensity CBT treatment delivery to those with OCD may indicate potential areas for further training and improvement of services.

Gaining practitioner feedback and experiences of how well a CBT intervention works in actual clinical practice across different contexts is vital because it creates a so called *'two-way bridge between research and practice'* (Wolf & Goldfried, 2013, p.7) so that empirical researchers can disseminate their findings to practicing clinicians and practicing clinicians can disseminate their experiences to researchers and the research community in addition to other practitioners as a means of improving practice and highlighting areas for further investigation (Wolf & Goldfried, 2013).

Research Question: How do CBT therapists experience the delivery of individual high-intensity CBT for clients with OCD?

Secondary research questions:

- What challenges do clinicians face in delivering CBT for OCD?
- What do clinicians perceive to influence client engagement with CBT for OCD?
- How do clinicians manage challenges associated with engagement and adherence to CBT for OCD?

1.11.2 Relevance of Research Project to Counselling Psychology

Counselling psychology adopts a humanistic phenomenological approach in which the subjective experience of the client is prioritised (BPS, 2005). Professional practice guidelines state that a level of congruence between the key principles and values of counselling psychology and the research methods adopted is desirable (BPS, 2005). This research study utilised a qualitative approach to understand clinicians' subjective experience of delivering individual high-intensity CBT for OCD, which aligns with the values underpinning counselling psychology. This investigation included the perspective of those working in the NHS. This may be particularly pertinent to counselling psychologists working in this area because these services are dominated by

the ‘medical model’, which emphasises quantitative analysis of outcome measures rather than subjective experiences (Marzillier & Hall, 2009). Counselling psychology adopts a critical and questioning view over the DSM-V (APA, 2013) categorization of psychological problems. By gaining practitioners’ subjective experiences of working within this medical framework of diagnostic categorization we may better understand the implications this system has on clinical practice and potentially on the individual client. In addition, a key criterion of the professional standards for counselling psychologists is to be able to *“critically reflect on the use of self in therapeutic practice”* (HCPC, 2015, p.12). Therefore research which focuses on elucidating therapists experience and the way in which their use of self in therapeutic work impacts on the therapeutic process is in line with the values of counselling psychology.

2.0 Methodology

2.1 Research Design

Research paradigms consist of congruent and interconnected philosophical and theoretical assumptions, which frame and direct the researcher in the conduct of their work and set the overarching context for the particular research endeavour (Ponterotto, 2005; O'Reilly & Kiyimba, 2015). Theoretical frameworks incorporate ontological positions concerning the nature of being, epistemological positions pertaining to the theory of knowledge and lastly methodological concerns denoting the way in which a topic is researched (Ponterotto, 2005). It is imperative that a researcher be explicit about the adopted theoretical framework in order that the underlying assumptions guiding the particular research project are clear (Willig, 2013). The theoretical framework of this research project will now be outlined along with the procedures and processes that were followed in the conduct of the study.

2.1.1 Epistemological Position

Within the body of research regarding CBT for OCD positivism appears to have been the dominant research paradigm adopted. Ontologically, positivism subscribes to the philosophical notion of realism, which suggests that there is one objective and measurable reality (Ponterotto, 2005) that is believed to exist independently of a person's beliefs or understanding of it (O'Reilly & Kiyimba, 2015). Epistemologically, positivism supports the dualist assertion that the researcher, research participant and topic of investigation are independent entities, which can be studied in an objective manner free from bias. The goal of research undertaken from within a positivist paradigm is, therefore, the production of objective knowledge (Willig, 2013). Quantitative methodologies involve the use of hypothetico-deductive methods of inquiry in order to verify or disconfirm an *a priori* hypothesis (Ponterotto, 2005). The positivist research that dominates the field of research regarding CBT for OCD allows the clinical effectiveness of the therapeutic approach to be ascertained however the subjective experience of the client receiving the therapy or the experience of the therapist delivering the therapy remains unaddressed.

In contrast to quantitative research, qualitative methodologies primarily explore the meaning a participant attributes to an experience as opposed to the detection of

correlational relationships (Willig, 2013). This research project aims to explore and understand therapists' subjective experience of delivering individual high-intensity CBT for OCD. The attempt to gain an understanding of the meanings attributed to a phenomenon by the research participants is consistent with a qualitative method of enquiry (Willig, 2013). A qualitative approach is consistent with the values of counselling psychology, which seeks to engage with clients' "*subjectivity, inter-subjectivity, values and beliefs*" (BPS, 2005, p.1).

Qualitative research can be situated in realism (one objective reality) or relativism (multiple equally valid realities). Qualitative research operating from a realist perspective aims to ascertain an understanding of social or psychological processes assumed to exist in the world independent of the participant's or researcher's awareness (Willig, 2013). Situated on the opposing end of the philosophical spectrum is relativism, which rejects the notion of one objective and absolute truth (Hansen, 2004). It is maintained that reality is constructed in the context of systems of language, culture and history and that such systems impact and determine perceptions, leading to the possibility of multiple, equally valid realities (Hansen, 2004). Within this approach, language is seen to construct the reality as opposed to the reality being the determinant of the way in which one talks about a phenomenon (Willig, 2013).

The ontological and epistemological position adopted in this research is critical realism, which is a philosophical notion residing along the continuum between realism and relativism. Ontologically, critical realism maintains the realist decree that there is an independently existing reality, yet acknowledges that this reality can only be measured imperfectly. Such a position proclaims that the way in which phenomena are experienced is subjective and determined by one's idiosyncratic beliefs (Bhaskar, 1978; Finlay, 2006). Therefore, critical realism advocates that there is one reality but that this can be interpreted in multiple different ways. Epistemologically critical realism does not assume that the data collected directly reflects reality but rather that this data needs to be interpreted in order to determine underlying structures (Willig, 2013). A modified dualist/objectivist stance is advocated which acknowledges that the researcher is inherently biased and may influence that which is being researched (Ponterotto, 2005). As such, I as the researcher accept that there is a reality of Obsessive Compulsive Disorder and Cognitive Behavioural Therapy. However, the way in which therapists

experience delivering CBT for clients with OCD will be subjective and idiosyncratic. A critical realist epistemological position is consistent with my clinical therapeutic practice and the underpinnings of counselling psychology, in which the unique experiences of each individual seek to be understood (BPS, 2005). Qualitative methodologies that are consistent with a critical realist theoretical position are those that seek to illuminate an individual's unique perspective and experience of a particular phenomenon (Finlay, 2006), which will now be explored.

2.2 Thematic Analysis

The chosen methodology for this research project is Thematic Analysis (TA). TA is a theoretically flexible method providing a set of tools allowing for the identification, analysis and reporting of patterns within a set of qualitative data (Braun & Clark, 2006). TA differs from other qualitative methods of inquiry, such as interpretative phenomenological analysis (IPA) or discourse analysis (DA), which are closely tied to set theoretical assumptions, involve precise guidelines for data collection and analysis (Clarke, Braun & Hayfield, 2015) and are often suited to particular forms of research. In contrast, TA is a method that can be applied across a range of theoretical frameworks and is not constrained to a particular form of research or research question. As such it is equally compatible with a realist paradigm as with a constructionist one (Clarke, Braun & Hayfield, 2015) and can be deployed to analyse most forms of qualitative data including interviews, focus groups and surveys (Clarke, Braun & Hayfield, 2015). TA was considered the most appropriate qualitative method for this study compared to other qualitative approaches such as Grounded Theory, which seeks to develop a new theory, or Narrative Analysis, which is interested in the way in which individuals impose order on their experiences to allow them to make sense of them (Willig, 2013). Interpretive phenomenological analysis (IPA), which enables an in-depth exploration of individual subjective experiences (Smith, Flowers & Larkin, 2009), was considered as a possible methodology for this study. However, IPA holds a distinct phenomenological epistemology and is less consistent with a critical realist epistemology, which was deemed most appropriate for this research question.

The flexibility of TA leads to a number of decisions that need to be made explicit by the researcher and will allow for the construction of a research design in which all the elements of the research are conceptually compatible (Willig, 2013). First, it is

imperative that the researcher clearly identifies the theoretical position from which the research is being conducted. In this case, the researcher subscribes to a critical realist ontology and epistemology as detailed above.

As outlined by Braun and Clark (2006), in addition to the particular theoretical position, the researcher must decide what counts as a theme and how the data will be analysed in order to identify said themes. A theme can be defined as something that both *"identifies a coherent aspect of the data and tells you something about it, relevant to your research question"* (Clarke, Braun & Hayfield, 2015, p. 236). It is suggested that researchers approach the identification of themes flexibly, allowing for their own subjective judgements to be involved in this process (Braun & Clark, 2006). The identification of themes can take one of two forms. The first is inductive analysis, in which the data is coded without a pre-existing coding frame or analytical preconceptions. In essence, the themes are rooted in the data itself, and aim to stay as close as possible to the data (Braun & Clark, 2006). While the aim of inductive analysis is to generate themes that are data-driven, it must be acknowledged that the researcher's theoretical assumptions, personal views and experiences, in addition to knowledge of the research area, will impact on the analysis (Clarke, Braun & Hayfield, 2015). In contrast to this, deductive thematic analysis involves producing a more detailed analysis of the data around a pre-existing theoretical concept that is often derived from previous research in the given area of study. Due to the exploratory nature of this particular study an inductive approach was deemed most appropriate.

Further to this, Braun and Clark (2006) suggest explicit decision-making be made regarding the level at which the analysis can take place, either at the semantic or latent level. A semantic level of analysis looks at that which is explicitly stated by the participant and remains close to the participant's meanings. This form of analysis is consistent with a realist epistemological position (Willig, 2013). In contrast, a latent level of analysis examines that which may underlie the surface data such as assumptions, personal views and frameworks (Clarke, Braun & Hayfield, 2015), which is consistent with a social constructionist epistemological position. Adopting a critical realist position allows for the data to be coded and themes generated at both the semantic and latent level (Joffe, 2012).

2.3 Ethical Considerations

2.3.1. Ethical Approval

Ethical approval for the study was granted by the University of East London ethics committee in May 2018 (Appendix 2.1) and amended in September 2018 (Appendix 2.2). Data collection began following receipt of the ethics application amendments approval in September 2018. All activity engaged in as part of this research project adhered to the core ethical principals outlined by the BPS '*Code of Ethics and Conduct*' (BPS, 2018) and the University of East London '*Code of Practice for Research Ethics'* (UEL, 2015).

2.3.2 Consent and Anonymity

The nature of this research project was outlined within the participant information sheet (Appendix 3) provided prior to an individual consenting to taking part. Participants were fully informed of their right to withdraw their consent to participate in the study at any time prior to the process of data analysis taking place. This information was clearly stated on the participant information sheet and the consent form.

The participant's privacy was maintained and respected by appropriately anonymising collected data (UEL, 2015). The participant was assigned a unique code number for all data analysis purposes. Policies and procedures for maintaining the confidentiality of participant personal data outlined within the University of East London 'Code of Practice for Research Ethics' (UEL, 2015) along with the Data Protection Act (2018) were upheld. Pseudonyms were assigned when referring to interview excerpts from participants in the write-up of the study. Information, which rendered the participant potentially identifiable, was not included in the write-up of the study and was removed from the transcripts. In addition, the specific public or private sector service in which the practitioner delivered their CBT treatment was not identified within the write-up or transcripts.

2.3.3 Participants' and Researchers' Safety

The potential risks to physical or psychological harm that may be caused by participating in this study were considered. The research did appear to pose a potential risk to the psychological wellbeing of participants as it is possible that interview

questions regarding the practitioner's experience of delivering CBT for OCD may cause negative self-evaluations regarding delivery of treatment, leading to the potential for anxiety and stress. In order to minimise this, the participant was reminded that they could stop the interview at any stage and that they were welcome to take breaks whenever needed. In addition, the participant debrief letter highlighted to the participant that they should discuss any issues that arose as a result of the interview with their clinical supervisor or personal therapist.

I informed my research supervisor of the location, time and date of any scheduled interviews and contacted my supervisor following the termination of each interview. The research interviews took place in a rented private room at a central London location. The interviews were only conducted during office hours and reception staff were available should any difficulties arise.

2.4 Participants

2.4.1 Sample Size

It is recommended that 6-15 participants constitutes an appropriate sample size for thematic analysis for professional doctorate programmes (Braun & Clarke, 2006). A homogeneous sample of qualified high-intensity CBT therapists, were recruited for participation in this study. One participant was recruited for a pilot interview along with ten further participants. The pilot interview was included in the analysis.

2.4.2 Inclusion Criteria

The participants were required to be qualified therapists who have delivered high-intensity CBT (including ERP) to clients with OCD and registered with the BABCP, which is the accrediting body for CBT therapists in the UK. Participants may also be registered with the Health and Care Professions Council (HCPC), which is the accrediting body for chartered psychologists in the UK. Participants may have delivered CBT to clients in private practice, within the National Health Service (NHS) or both. All participants taking part were required to be receiving regular clinical supervision of their practice.

2.4.3 Exclusion Criteria

Individuals not registered with BABCP as qualified CBT therapists were not eligible for inclusion. In addition, any participant that required the use of an interpreter was not eligible for participation in the study in order to prevent meaning being lost through translation.

2.4.4 Participant Details

Table two outlines the details of the participants. In order to protect participant anonymity, the age, ethnicity and the specific professional role of the participant have not been included.

Table 2: Table of participant information

Pseudonym	Years of Experience Delivering CBT	Accrediting Body
Charlotte	1 year	BABCP
Sarah	12 Years	BABCP
Amelia	9 Years	BABCP
Rachel	4 Years	BABCP
Ava	3 Years	HCPC & BABCP
Mark	7 Years	BABCP
Andy	9 Years	BABCP
Mia	9 Years	BABCP
Isabella	6 Years	HCPC & BABCP
Ella	9 Years	HCPC & BABCP
Camilla	6 Years	BABCP

2.4.5 Recruitment

Participants were recruited through professional networks. The British Psychological Society (BPS) list of chartered members and the BABCP online CBT register were also used to identify possible participants. A research poster (Appendix 4) was used to advertise the research study. This research poster was made available to potential participants via e-mail. It provided the contact details of the researcher and a request for the potential participant to make contact if they would be willing to be involved in the study. Once a potential participant made contact indicating they would be willing to

take part, a participant information sheet was provided to them. The information sheet outlined further details regarding the nature of the study, the data collection processes, procedures concerning storage of data and the limits to confidentiality. The potential participant was informed that anonymised extracts of the interviews would be incorporated into the final write-up of the research, which would be publicly available. The potential participant was then given time to carefully consider if they still wished to take part in the study in order to prevent any sense of coercion. It was made clear to participants that they were free to ask any further questions they had regarding the study at this stage. The potential participant was asked to contact the researcher via e-mail if they continued to be interested in taking part in the research study.

Following verbal or e-mail consent to take part in the study, a time and place to conduct the interview was arranged with the participant. All interviews took place face-to-face in a confidential setting. Participants signed the participant consent form (Appendix 5) prior to the interview commencing.

2.5 Data Collection

An appropriate form of data collection for thematic analysis is one that allows participants to share rich and detailed insights into the topic area (Braun & Clarke, 2006). Semi-structured interviewing is a useful method of collecting such data (Willig, 2013). The materials and process of conducting such interviews are outlined below.

2.5.1 Materials

Digital Recorder: All interviews were audio-recorded with the participant's consent using a digital voice recorder (Olympus WS-6505). Following each interview the audio recording was immediately transferred onto a password-protected computer accessible only to the researcher. The original recording stored on the voice recorder was then destroyed.

Interview Schedule: An interview schedule (Appendix 6) was designed in conjunction with the research supervisor and following a detailed literature review. The schedule incorporated open-ended questions designed to elicit participant perceptions of their experience of delivering high-intensity CBT to clients with OCD. Interview questions were asked in an open-ended and non-directive manner in order to allow the participant

the opportunity to share their experience in their own words. The interviews were participant-led, meaning that the order and number of interview questions that were asked varied. This was to ensure that the participants felt free to elaborate on their experience and express their own perceptions.

Following UEL ethical approval, a pilot interview was conducted with an individual meeting the stated inclusion criteria. This was carried out in order to ensure that the questions were comprehensible and provided an opportunity to gain rich and detailed data related to the research question. Following the pilot interview the participant was asked to comment on the interview process. In addition, the researcher listened to the interview and discussed this process with the research supervisor. From this it was decided that some additional prompts were needed in order to further elicit the participant's subjective experience of delivering CBT for OCD. These prompts were added to the interview schedule.

2.5.2 Interview Process

Each interview began with a discussion regarding the participant information sheet and the participant was given space to ask any questions they may have. The general nature of the types of questions the interviewee would be asked was outlined and the confidentiality and anonymity policy was fully discussed prior to initiating the interview. Interviewees were reminded that they could terminate the interview at any stage if they wished to do so.

Once the participant's written informed consent was gained, all interviews were audio-recorded. A debrief was conducted at the end of the interview in order to allow the participant to share their reflections on the interview process. The interviewee was reminded that if any distress had been caused by the interview they should speak to their clinical supervisor in the first instance and were provided with a de-brief sheet (Appendix 7). No participants expressed experiencing any distress from the interview process.

2.6 Data Analysis

2.6.1 Transcription

A transcript was produced for each audio recording. All identifying information was removed from the transcripts. Transcription conventions outlined by Parker (2005) were used (Appendix 8). The initial transcriptions were crosschecked against the audio recording in order to ensure the accuracy of the data. All anonymised transcripts were stored on a password-protected computer accessible only to the researcher. No specific transcription software was used.

2.6.2 Process of Thematic Analysis

Braun and Clark (2006) outline six key phases of conducting a thematic analysis (Table 3). These were followed during the data analysis phase and are described below.

Table 3: Phases of Thematic Analysis (after Braun & Clark, 2006)

Familiarisation	Initial engagement with the data involving reading and re-reading transcripts.
Coding	The systematic labelling data of interest that is related to the research question.
Searching for Themes	Initial codes are collated into themes that represent patterns in the data.
Reviewing Themes	Ensuring the themes generated are supported at the level of the coded data and across the entire data set.
Defining and Naming Themes	Identifying appropriately clear names and definitions for themes.
Writing the report	An analytic narrative is combined with data extracts in order to produce a convincing analysis.

Phase one: Familiarisation

I familiarised myself with the collected data through a process of data immersion, which I embarked upon in a questioning and curious manner. This involved listening to each

audio-recording in order to complete the transcriptions, undertaking multiple readings of these transcripts and producing notes of preliminary observations in the left-hand margin of the transcript.

Phase two: Coding

Coding involves the grouping together of relevant data from across the data set. A code can be defined as "*the most basic segment or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon*" (Boyatzis, 1998, p. 63) and can be identified by working systematically line-by-line through the entire data set. Each transcript was analysed individually and was coded in its entirety before moving onto the next transcript (see Appendix 9 for an example of a coded transcript). Potential codes were written onto the transcripts in the right hand margin. The data was coded at both the semantic and latent level. The end of this phase resulted in a table of codes (Appendix 10.1), and all relevant data extracts to support each code were collated into an additional document (Appendix 10.2). Two rounds of coding took place before progression onto the next stage of analysis to ensure the coding was comprehensive.

Phase three: Searching for themes

This phase involves the process of theme development. During this stage it is essential to ensure that potential themes identify both an important aspect of the data and tell the reader something about the nature of this data. Codes were clustered together and aligned into potential themes that I felt satisfied these two aims. A table was used at this stage to group together the relevant codes into potential themes. This stage of the analysis produced twelve candidate themes (Appendix 10.3).

Phase four: Reviewing themes

Phase four involved reviewing generated themes, which occurred at two levels. Firstly, the collated codes for each individual theme were revisited to check there was a 'good fit' and that they coalesced into a coherent pattern. In order to achieve this, all data relevant to each group of codes was re-read to check that there was sufficient 'fit' with the proposed theme. The concepts of internal homogeneity and external heterogeneity are important here and were considered such that each theme had internal consistency but that each theme was distinct and did not overlap with others (Braun & Clark, 2006).

Level two of this stage involved examining the individual themes in relation to the data set as a whole. I also began to examine the links and connections between the themes. At this stage, out of the twelve potential themes, four higher-order themes each with three sub-themes were identified and a thematic map was produced (Appendix 10.4). I attempted to clarify whether the thematic map represented the meanings within the entire data set. In order to achieve this, the data set was re-visited to ensure that there was no missing data that had not been captured by the coding process.

Phase five: Defining themes

Once a satisfactory initial thematic map was settled the research progressed to stage five of the analysis involving defining and refining my themes. Theme definitions were used at this stage to provide a summary of the central organising concepts, scope and boundaries of each theme. At this point I began to ascertain the 'story' that was being told by each theme and an analytic narrative began to develop in which the flow of analysis both within each individual theme and across the entire data set was considered such that an overall 'story' was developed in relation to the research question. At this point the theme names were revisited in order to better represent the experiences of the participants and two of the themes were re-named, because as Braun and Clarke observe *"Names need to be concise, punchy and immediately give the reader a sense of what the theme is about"* (Braun & Clarke, 2006, p. 23). This stage produced the final thematic map (Appendix 10.5). In order to demonstrate the validity of the analysis, data extracts have been provided in the findings section, which demonstrate and evidence the themes from across the entire data set. These extracts act to support the overarching story and are woven into the analytic narrative.

2.7 Researcher Self-Reflexivity

In order to ensure the credibility and transparency of qualitative research it is vital that the researcher engages in a process of reflexivity which involves the explicit consideration of the ways in which the researcher has influenced and impacted upon the research process (Smith, 2015). Within TA, researchers' assumptions and presuppositions are seen to be involved in the process of generating themes (Braun & Clarke, 2006). The important facet of reflexivity is to identify the *"specific ways in which our own agenda affect the research at all points in the research process"* (Hesse-Biber, 2007, p.17). In order to enhance my reflexivity I kept a reflexive journal

thorough out the research process including the recruitment and interview stages. Extracts from this journal are presented in Appendix 11.1 and 11.2. Self-reflexivity is an important aspect of research rigour and the impact of my own assumptions on all stages of the research process is addressed in detail in section 4.5.

3.0 Findings

This chapter presents the findings that were produced by the analysis of the participant interviews and highlights their experience of delivering individual high-intensity CBT (including ERP) to clients with OCD. The analysis indicates four discrete themes that encapsulate the participants' subjective experiences. Each theme, along with the relevant subthemes, is shown in Figure 1. A discussion regarding each theme and subtheme is presented along with the raw data extracts for illustrative and supportive purposes. A pseudonym has been provided for each extract along with the line location in the relevant transcript. While brief interjections and interruptions were initially transcribed, they have been removed from the extracts to improve readability.

Figure 1: A thematic map of themes relating to clinicians' experiences of delivering CBT to clients with OCD

Major Theme	Sub-themes
1. Drowning in the complexity	Tangled in a web of steel
	Unprepared
	Lost in convoluted co-morbidity
2. Boxed In and Shut out	Contextual constraints
	Shut out by the client
	Limits of the model
3. Desperately seeking control	Follow my lead
	Plan. Plan. Plan.
	Disintegrating Alliance
4. Frustrated Practice	Not enough
	Internal Conflict
	Fleeing the client

3.1 Theme One: Drowning in the Complexity

Many participants interviewed described OCD as an entrenched entity that appeared to be inextricably part of the individual's personality. This seemed to result in an overall sense of the condition having a powerful grip on an individual that would be a significant challenge to loosen. In addition to this sense of OCD being unmovable, it was simultaneously viewed as *"elusive" (Rachel: 202)* owing to the changeable nature of the intrusive thoughts and compulsions that the clients presented with. These two factors appeared to result in the participants experiencing a sense of being lost and tangled in a web of symptoms that was difficult to navigate and find a clear path through. For example, Charlotte expressed a sense of the relentlessness and the persistence of a condition that was forever changing (*"you deal with one thing and then another sort of behaviour crops up", Charlotte: 53)*. Adding to this was the presence of other mental health conditions which appeared to have created confusion amongst the participants regarding what aspects of the client's symptoms needed to be addressed in treatment. Some participants appeared to express a sense of feeling unprepared for delivering treatment to this client group, due to lack of adequate training based upon the intricacies of real clinical patients. The predefined 'map' presented to them in training was often difficult to translate into the reality of clinical practice. The resulting impact on the participants appeared to be a concern that they may become engulfed and consumed by the condition, resulting in a desire to not get too close to the client's experience and endeavouring to keep clients at arm's length. This desire to maintain distance may have implications for the therapeutic relationship as the therapeutic bond made up of reciprocal positive feelings may be more difficult to maintain in these circumstances.

3.1.1 Sub-Theme: Tangled in a Web of Steel

The client's OCD-related intrusive thoughts and compulsions appeared to be experienced by the participants as difficult to conceptualise and hold onto ("*it was almost like elusive, I couldn't quite capture what was happening", Rachel: 201)*. Several participants appeared to experience a sense of being unable to easily define and identify the symptoms presented by the client due to their constantly evolving nature. Such an experience appeared to result in a sense of attempting to work with a condition that was somewhat out of reach and that frequently slipped through their fingers, an experience which may mirror the clients' own sense of being trapped within their

condition and not knowing how to find a way out. This experience of working with the perceived evasiveness of OCD was exemplified by Amelia below:

"there was far too much and the feeling was where do I start from, yeah you know it is too complex, there is too many things going on every turn you take there is something else coming up and that was often, especially at the beginning of my training, the feeling that I got, I was feeling feeling a bit lost err you know with all this data and the different things that the client was presenting" (Amelia: 200)

Amelia's use of the phrases *"far too much"* and *"too complex"* suggest a sense of being overwhelmed by the array of different intrusions and compulsions reported by the client and struggling to make sense of what was happening. It appears that Amelia was attempting to follow a treatment plan owing to the use of her language conveying an attempt to follow a direction *("every turn you take")*. These endeavours to follow a predefined map appeared to be hampered by the multitude and the complexity of the reported intrusions *("there is too many things going on")* resulting in her struggling to know how to manage and where to begin *("where do I start from")*. This appears to have resulted in Amelia experiencing a sense of being out of her depth *("I was feeling feeling a bit lost")* and trapped within the web of symptoms. This sense of being engulfed and trapped may threaten the therapist and impact on their ability to provide a secure, predictable and empathic therapeutic relationship with the client. A potentially weakened alliance may have implications for the client's willingness to engage in the more challenging aspects of the treatment such as ERP.

This sense of not having a clear route through the problem (*"you might feel quite stuck you might not kind of know where to go" Isabella: 237)* and becoming entangled in the web of intrusions appeared to cause concern amongst participants about being overcome by the complexity of the condition, which is demonstrated through Rachel's reflection below:

"trying to maintain as I mentioned before that sort of one foot in the anxiety one foot in the OCD world and one foot in the reality CBT world and not getting stuck into the nuance and spotting spotting when that is happening sooner and really taking an overall like this is just one, this is anxiety" (Rachel:974)

Rachel's focus appears to be on preventing being sucked into the OCD conveying a sense of experiencing the condition as a powerful force that may consume her. She seems to be attempting a balancing act in which she experiences a need to maintain a firm hold on her understanding of the problem through the prism of the CBT model and entrenches herself within this (*"one foot in the reality CBT world"*) while simultaneously attempting to get close enough to the client's experience in order to understand their subjective experience *("one foot in the OCD world")*. She appears to be constantly alert to the possibility of the *"OCD world"* taking hold and the importance of *"spotting"* this quickly and taking a step back *("really taking an overall like this is just one, this is anxiety").* The resulting impact of this balancing act may present difficulties for the participant in the development of the therapeutic relationship with the client as it seems that while participants may have wanted to understand and offer help to their clients they appeared equally wary of becoming engulfed by the condition and demonstrated some resistance to fully relating to the client.

Notably, one participant described her fears of actually developing OCD herself as a result of working with these clients (*"a slight fear that I could end up with OCD if I start checking", Sarah:63).* Sarah appeared to be expressing the idea that through working with clients with OCD she herself may start and be unable to refrain from undertaking compulsive checking behaviours. This perhaps indicates the therapist's sense of feeling somewhat vulnerable when working with this client group due to concerns that they themselves could become tangled up with the client in their complex web of symptoms. The impact of this may be that the participant is distracted by these concerns when in treatment with the client, which may further affect the development of the therapeutic relationship.

The sense of being lost in the complexity appeared to be heightened when aspects of religion or culture were involved in client's intrusive thoughts. This is exemplified by Sarah who stated:

"one other client we had and it was somebody who was Muslim so one of the rituals was around washing so many times you know before praying or reading the Quran and it was really hard to differentiate between what was religion and what was not

and at those times not feeling confident you can't really support the client" (Sarah: 306)

Sarah's use of the phrase *"it was really hard"* emphasises how challenging she found navigating the religious element of the client's intrusive thoughts resulting in her questioning if she would be able to provide adequate treatment *("you can't really support the client").* Her perceived inability to separate what was part of the OCD and what could constitute typical religious practices seemed to result in a confidence crisis and a sense that any support she offered to the client would not be appropriate. The resulting impact on the participant of attempting to manage intrusive thoughts with a religious element appeared to be a greater sense of being unclear about what direction to take in treatment. This may have an impact on the therapeutic relationship as the client may struggle to feel understood and contained if the clinician themselves is experiencing difficulty comprehending the client's intrusions and compulsions.

3.1.2: Sub-Theme: Unprepared

Compounding the participant's experience of being lost in treatment was the apparent difficulty that was faced regarding translating the CBT protocol disseminated in their training into 'real life' clinical practice. Several participants brought up the focus on unrealistic *"textbook"* (*Ava:1518*) clients being used in training, which did not adequately prepare them for the complexities of clinical practice. For example, Andy stated *"so the case studies that you read about you know they just don't seem like the reality of what we are seeing" (Andy:279)*. Andy appears to demonstrate the disconnect between the passive reading in a training session in which sterilised case studies are presented which do not reflect the nature of what he is experiencing in clinical practice. The impact of this appears to be a sense of being uncertain of how best to adapt the protocol when working with the intricacies of clients. There appears to have been a lack of guidance on this front with regards to managing co-morbidity or how to adapt the protocol for clients who are struggling to engage with the CBT techniques. Rachel suggests that more detailed and rich examples would have been of benefit in order to prepare her for this:

"there weren't a lot of examples it was all quite theoretical and I found it quite difficult umm so when I started treating people with OCD I was kind of on the fence whether about how I felt about it" (Rachel:32)

Rachel highlights the impact of the *"theoretical"* training she received on her view of OCD as an overall problem and the impact of this in terms of her hesitation about working with this client group *("I found it quite difficult")*. The lack of reference points *("there weren't a lot of examples")* during training may have resulted in a sense of being adrift when faced with a client in clinical practice without a firm understanding of the model or how to adapt it to meet the client's needs. Rachel generated an image of being *"on the fence"* which once again conveys uncertainty regarding whether she felt confident or not with the treatment she was offering. It suggests she experienced the possibility of the treatment going one way or the other. This uncertainty may have impacted on the therapeutic relationship as the participants appeared preoccupied with attempting to follow the 'right' protocol which may have detracted from the time spent focusing on and fostering the therapeutic bond between themselves and the client.

3.1.3 Sub-Theme: Lost in convoluted co-morbidity

Many participants interviewed described a sense that they were frequently working with co-morbid mental health difficulties in addition to the primary OCD diagnosis. The participants interviewed perceived the presence of co-morbid conditions creating confusion and adding to their sense of being unclear on the way forward in treatment. Trauma appeared to be the most frequently encountered co-morbid issue which was experienced by the participants as creating a barrier to implementing the model, as described by Sarah below:

"what came through was a trauma in childhood which actually triggered the OCD in the first place and some of those traumas were not resolved and they had an issue in terms of developmental trauma so and umm he couldn't really engage with the exposure and response prevention treatment" (Sarah:35)

Sarah appears to be indicating the need for childhood trauma to be *"resolved"* before work could be done specifically on OCD symptoms. Sarah experiences the CBT treatment model as potentially limiting because the recommended protocol does not

adequately address contributing past experiences or account for the possibility of additional issues interfering with the treatment protocol. The impact of attempting to work with a client with co-morbid trauma appears to result in client resistance to the specific techniques ("*he couldn't really engage with the exposure and response prevention treatment")* leaving the participant and the client trapped in a model that perhaps is not able to adequately address the complexities of the client's presentation. The participant seems to be experiencing a dead end in the maze of symptoms without any guidance on which way to proceed, heightening her sense of being lost and stuck. Several participants appeared to suggest that the deficiencies in the model meant that not all clients may be appropriate for CBT and that perhaps other co-morbid issues need to be addressed before attempting to engage in this form of work; or guidance regarding other techniques that could be used to resolve the added complication of these difficulties may need to be provided to practitioners and incorporated into the model.

The desire to match clients' experiences to pre-defined diagnostic labels appeared to heighten participants' experiences of drowning in the complexity. Andy indicates his experience of the overlap between trauma and OCD and the challenge with differentiating between these two conditions (*"We literally spent about four sessions trying to decide if it was PTSD or OCD, they were so intertwined" Andy:184)* which led to a significant amount of time in therapy being devoted to teasing the two apart. The impact of this appeared to be that choosing a diagnostic label may distract the practitioner from taking a holistic view of the client's difficulties and result in a reductionist approach to treatment. This need to fit the client into a pre-defined diagnosis and the problems with this approach were identified by Rachel:

"I think sometimes in CBT we get too stuck into diagnosis when if they have got OCD there is probably some GAD there is probably some depression and there is probably some of this and some of that and actually just pulling back more often and kind of thinking a little bit more broadly" (Rachel: 981)

Rachel's use of the phrase *"we get too stuck into the diagnosis"* captures a sense that the diagnostic label is experienced as restrictive, potentially resulting in a reductionist way of viewing the client and the complexities of the web of symptoms. Rachel suggests that a more global and holistic approach could be useful when working with

clients with OCD *("just pulling back more often and kind of thinking a little bit more broadly")* given the frequent presence of other co-morbid difficulties. The phrase *"some of this and some of that"* encapsulates her experience of not working with one discrete set of symptoms but rather a combination of a range of symptoms which could theoretically fall into a number of different diagnostic categories and may all impact on one another. Rachel emphasises the need to come back to the essence of the purpose of the treatment and to focus on the client. This seems to convey Rachel's attempt to disentangle herself from the web of symptoms in order to provide the best treatment for the person in front of her.

3.2 Theme Two: Boxed In and Shut out

In addition to the perceived complexity of the condition it also appeared that when working with OCD the participants experienced different forms of limitations on their practice. Firstly, the actual context in which the work was taking place, NHS or private practice, appeared to have an impact on how the participant was able to make use of the CBT interventions. Further to the context, the CBT model itself appeared to be experienced as restrictive by some participants because it did not adequately address affect tolerance, emotional regulation or the co-morbid problems. Lastly, participants appeared to experience and perceive the clients themselves as restrictive due to being frequently confronted by resistance to the therapeutic techniques, in particular to the behavioural element of the work and problems with disclosing intrusive thoughts.

3.2.1 Sub-Theme: Contextual Constraints

The majority of participants described the ways in which their working environment affected the CBT they delivered. Those working in the NHS within IAPT services felt constrained by the number of sessions available which they experienced as limiting their ability to gain a full conceptualisation of the client's difficulties along with hampering what could be done in the therapy time available:

"you have just got to the point where you have completed your assessment and formulation and you are trying to get the client on board with umm the formulation and why it might be helpful to start umm challenging the OCD and reducing some of the compulsions and then the sessions are over" (Ella: 89)

Ella observes that completing a full assessment of the client's difficulties in itself is a lengthy process suggesting that this stage in the treatment requires sufficient time. She also expresses the challenge of having to *"get the client on board"* with the formulation, again requiring time which leaves little opportunity to complete the actual intervention in terms of engaging the client in techniques to overcome the OCD. There appears to be an implicit sense of exasperation in Ella's statement, perhaps owing to her perception of OCD as requiring extra effort due to the difficulties with building a rationale for treatment and engaging the client, which appears to clash with the limited time provided in an IAPT setting. The impact of this is that the participant feels constrained and constricted in their practice, which may have implications for the therapeutic style that is being used in treatment with such clients. If there is a focus on time efficiency this may open up the possibility of the therapist overlooking or invalidating the client's emotional experience which could have implications for the therapeutic relationship.

The majority of participants spoke about the lack of freedom within an NHS context. For example, participants reported they would like to be physically present with the client during ERP but that time constraints prevented this, suggesting the participants experienced barriers in being able to complete 'therapist-directed/therapist-conducted' ERP. This may have significant implications on the outcome of the therapy because this form of ERP has been demonstrated to be the most effective for OCD symptoms (Tolin, 2007). In addition to having an impact on what is possible in the therapy the time-limited context also appeared to have an emotional and physical impact on the participants. This is vividly described by Mia who stated:

"Sometimes it can be quite stressful *<I:Mmm yeah>* ***sometimes I have to be honest I can feel sick physically yeah*** *<I: you feel physically sick with not having that time>* ***yeah you are constantly back to back" (Mia: 527)***

Mia clearly articulates the physical *("I can feel sick")* and emotional *("it can be quite stressful")* impact of the IAPT environment, in which there seems to be little time to reflect *("yeah you are constantly back to back")*. The time constraints within this setting appear to have limited her ability to reflect on her practice and to maintain her own self-care. A lack of time for reflection could have implications for the therapeutic

alliance because the therapist may become unaware of their own contribution to the interpersonal processes in treatment with a client, potentially resulting in 'mistakes' being made in treatment.

The freedom of working in a private context appeared to enhance the experience of delivering ERP and those participants working in this setting frequently reported more positive experiences of clients benefiting from the exposure tasks. For example, Andy reported several occasions when he had been to the client's home to complete exposure, which he regarded as particularly beneficial.

"I can also observe them I get to see a lot more about how it affects them and you can access more cognitions with them in the moment you know things that they weren't even aware of themselves umm and that just helps you think about what else you need to address so it gives you a lot more information as well when you do it with them so you can coach them through it." (Andy: 507)

It would appear that the therapist being physically present with the client when undertaking exposure and having the opportunity to witness the client carrying out rituals allows for a more thorough conceptualisation of the client's problems. The impact of this is that the therapist themselves appears to become more actively engaged in the process of exposure resulting in a greater sense of collaboration *("when you do it with them")*. Overall, the experience of the participants suggests that the clinical setting impacted on the level of collaboration generated. Therefore, when working in an NHS context, the time restrictions may hamper the therapists' ability to work with the client collaboratively, because the opportunities to complete ERP with the client outside of the therapy room are reduced.

Further to the contextual constraints of the setting in which treatment was delivered, participants also appeared to experience a sense of being constrained by barriers related to the clients' home environments and the impact of friends and family on the condition itself and on the delivery of treatment. In some instances, participants experienced family as interfering with the therapy. For example, Amelia described problems she experienced with family members and the emotional impact this had on her:

***"Well it was it was very difficult because I had to send e-mails to mum explaining, I felt that I had to justify myself for the treatment not working when in fact it had nothing to do with me and it was more to do with him not wanting to do the homework so mum was very defensive and protective of her son which I found really really irritating at times and then in the session I would feel umm very irritated by the client*" (Amelia: 400)**

Amelia describes the overall burden *("it was very difficult")* of the perceived interference of the client's mother on the process of treatment and a sense of being forced into defending the treatment she was delivering (*"I felt that I had to justify myself"*). A power dynamic between the participant and the client's mother appears to have been established in which each feels a sense of having to protect what is important to them. Amelia seems to attempt to distance herself from the treatment which she perceives as *"not working"* through locating the problems being encountered resulting solely from the client *"it had nothing to do with me and it was more to do with him not wanting to do the homework".* The sense of irritation that Amelia feels towards the client's mother was brought into the therapy room and transferred onto the client *("so mum was very defensive and protective of her son which I found really really irritating at times and then in the session I would feel umm very irritated by the client")* which ultimately appears to have culminated in a rupture in the therapeutic alliance, seeming to result in both the participant and the client resisting engaging in the treatment. There was limited reflection at this stage on the part of Amelia regarding the extent to which she may be contributing to the resistance the client is demonstrating in the therapeutic work.

Further to the perceived interference from family members, other participants discussed the difficulty of treatment progressing due to friends and family unwittingly maintaining the OCD. However, despite participants' awareness of the complication of family or friends inadvertently maintaining the problem, only rarely did participants actually involve family or friends in the treatment, as demonstrated by Ella:

"Well I haven't really asked about it because I know how important it is but I have never umm invited them in but since that training I think I will do that because I really see the value in that in speeding up the process" (Ella: 405)

There appears to be an implicit reluctance and resistance within Ella to approaching the topic of inviting family members or friends to be a part of the treatment *("Well I haven't really asked about it")* despite being consciously aware of how important it is. Additional training may have encouraged Ella to involve family or friends in treatment in the future seemingly as a means of aiding improvement in the client's symptoms in a timelier manner *("speeding up the process")* which may be particularly pertinent when working in a time limited context such as the NHS.

3.2.2 Sub-Theme: Shut out by the client

In addition to environmental and contextual constraints experienced by many participants leading to a sense of being boxed in there was also a sense of being shut-out by the client due to their resistance to engaging in therapy, most notably with regards to disclosing intrusive thoughts and undertaking behavioural work. This sense of a barrier being experienced between the client and therapist was powerfully expressed by Sarah through the metaphor of a shut door:

"Frustrating [participant laughing] really hard actually because you feel quite helpless and also lost because umm because it is almost like my image is of this door being shut and you are desperately banging on the door to get in and you just can't find the door to get in" (Sarah:444)

The door in Sarah's image appears to represent all of the challenges she faced in terms of attempting to engage clients in treatment. Being unable to "*find the door to get in*" clearly has had an impact on her emotionally *("you feel quite helpless and also lost")*. Her laughter when discussing this may be a defence against the discomfort she experiences when remembering these events. She appears to convey a sense of frantic urgency *("desperately")* when describing her attempts to find a means of accessing the client's experience and having to put in considerable effort in treatment in order to do this. This need for force is conveyed through the visual image of *"banging on the door",* suggesting a sense of requiring power in order to try to engage the client. The impact of this appears to be the development of a difficult therapeutic dynamic in which the participant is becoming desperate and consequently adopting a more domineering and forceful approach, which only seems to strengthen the barrier between the

participant and the client. The image of a door between the participant and the client implies a lack of collaboration and teamwork. Sarah's efforts to produce change seem to have left her struggling to simply be with the client, as she seems preoccupied with finding *"the door to get in"*. Such a dynamic may generate the potential for ruptures in the therapeutic alliance, potentially leading to the client pulling further away from her and from engaging in therapeutic techniques.

In particular, clients completing exposure tasks on their own as homework were a significant challenge experienced by the participants, exemplified by Amelia:

"what I remember the most about treating people with OCD was that things would kind of be ok in the session so long as you had that sort of motivational power, that is so important especially when treating people with OCD, but then them not being able to you know do what was required you know outside of the session and then having the frustration of having to try and work out why and how you could actually overcome that obstacle" (Amelia: 323)

Clients' difficulties in completing homework tasks represent Amelia's chief memory *("what I remember the most")* of treating clients with OCD indicating the significance of this experience for her and the lasting impression it had. In session, Amelia appears to place the responsibility for the client's engagement onto herself and references the importance of the impact of her own *"motivational power"* in enabling this to happen. This highlights Amelia's perception that some degree of strength on the part of the therapist is needed in treatment with such clients, in order to enable them to engage in treatment. However, outside of the therapy session Amelia shifts the responsibility onto the client *("them not being able to you know do what was required you know outside of the session").* High expectations are placed onto the client and a resulting impatience on the part of the participant ensues when the client is not able to meet her expectations. The impact of this may be an increased potential for the establishment of a difficult dynamic where the client may feel they are 'failing' to meet the standards set by the participant, leading to the potential for client avoidance of therapy sessions. Amelia takes it upon herself to *"try and work out why and how you could actually overcome that obstacle"* rather than viewing this as a shared endeavour between herself and the client. Amelia may be experiencing a feeling of responsibility for finding the 'solution'

for the client's lack of engagement which places a large amount of pressure on both the participant in terms of generating the 'solution' and on the client feeling controlled or pressured into complying with this solution.

3.2.3 Sub-Theme: Limits of the model

In response to the experience of being shut out by the client, many participants reported that it had been necessary to use therapeutic techniques that went beyond the standard CBT protocol for OCD. The inclusion of these additional techniques suggests that some participants experienced a sense of being boxed in by the model and attempted to break out of this. This is exemplified by Mia who stated, *"in some clients, all the way CBT is enough, but in some clients CBT is not enough, you have to engage in some other techniques which is normal, which is quite common"* (*Mia: 397*). Participants appear to have adapted their practice towards a more assimilative integrative approach using CBT as the core model. For example, several participants interviewed spoke about the need to introduce emotional regulation and distress tolerance strategies prior to completing the ERP work.

"I think what was coming through was he had really low distress tolerance so he couldn't really engage with it and I suppose in a way what you needed was almost another piece of work and might have needed a relational piece of work and I think that was picking up from my psychotherapy training for him to feel a sense of safeness to engage with OCD work because I think with CBT the treatment we offer we assume that they have got a certain degree of emotional regulation or distress tolerance to engage with that level of affect and I don't think that this client had it so I feel he almost needed something more in order to then engage with exposure and response prevention" (Sarah:101)

Sarah describes her experience of working with clients with low distress tolerance and the difficulties that this created when attempting to introduce ERP work. Sarah appears to be highlighting the deficits in the CBT model suggesting that "*another piece of work"* was needed to properly provide for the client's needs. Through suggesting a *"relational piece of work"* Sarah may be implicitly suggesting that there is a lack of focus on the relationship in standard CBT which is needed if clients with distress tolerance issues are going to *"feel a sense of safeness".* Sarah highlights the

assumptions that are made by the CBT model *("we assume that they have got a certain degree of emotional regulation or distress tolerance")* and that if emotional dysregulation is present then *"something more"* beyond CBT is required to help those clients. An issue raised here is the identification of those who may not be suitable for CBT work and may require other forms of therapy in order to be able to work directly on OCD symptoms in the future using a standard CBT protocol. The impact of this appears to be that Sarah gave up on the model being effective for this client *("I don't think that this client had it so I feel he almost needed something more")* perhaps leading to a sense of being restrained and restricted in her practice without the tools to add in the additional work that she perceives would better meet the client's needs.

Further to the need for distress tolerance work, clinicians appeared to be incorporating other techniques into the standard CBT model in response to feeling shut out by the client. This was especially important when childhood trauma had been identified (*"I think compassionate mind, I think you have to use it with clients especially when they have early childhood trauma" Mia:430).* Mia appears to be advocating the need for the client to develop a sense of compassion in addition to engaging in standard CBT techniques. She views compassion as vital *("I think you have to use it")* when there has been an absence of such compassion in the client's early life.

Many participants referred to devoting time to eliciting the client's values and making use of this as a means of encouraging engagement with ERP *("what are the things they want to do in their life, what do they enjoy, what do they love doing" Ava: 155).* Participants appeared to spend time with clients attempting to understand the impact of OCD on the different areas of their lives and in doing so appeared to be wanting to enhance motivation to engage in therapy through emphasising what OCD is currently depriving them of. This resembles the approach adopted by motivational interviewing in which the therapist aids the client to verbalise a discrepancy between their current behaviour and strongly held values and goals (Simpson et al., 2010). Many participants referenced motivational techniques as a specific therapeutic factor they added to the standard CBT protocol as a means of fostering and facilitating client engagement as reported by Andy:

"you kind of have to get to know the patient, so what are their passions and stuff like that, what would they like to be doing so things like that it is kind of beyond the protocol shall we say it is knowing the patient's kind of lifestyle a little bit umm so that you can find those things that are important to them and find those things that essentially you can use umm which sometimes can feel a little bit manipulative actually" (Andy:82)

Andy appears to be describing a process of eliciting the client's desire, need and reasons to change. He seems to view this process of getting to know the client's idiosyncratic reasons for change as *"beyond the protocol"* suggesting this is not something that would be done within a standard CBT intervention for OCD. Andy also wants to seek out those things that the client currently is not doing *("what would they like to be doing")* and *"use*" this as motivation to engage the client in treatment. While this approach is clearly adopted by Andy, presumably because it fosters client engagement, it is apparent that he has some sense of unease about it; even going as far as to say he feels such an approach *"can feel a little bit manipulative",* suggesting that Andy has become uncomfortable with the power dynamic within the therapeutic relationship. Andy seems to implicitly recognise that as the client becomes more transparent in terms of divulging their values and goals, they inherently become more exposed. Due to the therapist remaining opaque, as he does not reciprocate a divulgence of personal information, an unequal relationship is developing in which the therapist holds more knowledge and therefore a sense of power, which appears to be experienced by the participant as manipulative because this knowledge is being used to get the client to engage.

Several participants acknowledged that specific therapeutic techniques, CBT or otherwise, could only go so far and that the non-specific factor of the therapeutic relationship was important to attend to. Participants referenced the use of Carl Rogers' (1957) core conditions such as empathy, acceptance and unconditional positive regard for the client as being important in developing and maintaining the therapeutic relationship. One means through which several participants attempted to foster these core conditions and strengthen the therapeutic relationship was through the use of humour in their clinical practice as can be seen through Amelia's quote below:

"I found that actually having that attitude of actually trying to lighten things up actually would then help the client to muster the courage to do it themselves" (Amelia:62)

Amelia appears to suggest that the use of humour is a helpful way of encouraging the client to engage in exposure. The use of the phrase *"lighten things up"* suggests that she finds the treatment somewhat heavy and is seeking a way out of this. Two further non-specific factors that were identified in the data as being employed by participants in an attempt to facilitate client engagement were firstly the establishment of a credible rationale for treatment and secondly the provision of a clear 'explanation' regarding the factors maintaining the client's intrusions and compulsions. These are considered non-specific factors to the extent that all psychological therapies provide some form of explanation for the client's symptoms and establish a rationale for treatment regardless of the content of this explanation and rationale (Frank, 1982). The ability to provide a framework for making sense of the client's difficulties was emotive for some participants, for example Ella stated:

"I think of all of the presentations I have seen the relief on someone's face when you explain this is OCD and this is very very different to being an actual paedophile is just yeah it is one of those moments where you yeah the expression on their faces you have one of those days at work where you think oh wow it's like [participant laughing] it felt good to be able to explain it to them" (Ella:201)

Ella identifies that providing an explanation of the client's difficulties *("when you explain this is OCD and this is very very different to being an actual paedophile")* can generate a particularly notable level of relief for the client which is viewed as above and beyond what may be witnessed with other presentations. This suggests that this non-specific factor may play an important function in creating hope in the client and thereby developing the therapeutic relationship. Being in a position of being able to offer this explanation to the client appeared important to Ella and to her own perception of being able to help the client *("you think oh wow it's like [participant laughing] it felt good to be able to explain it to them")*.

3.3: Theme Three: Desperately Seeking Control

It appeared that participants experienced a need to engage in a range of over-compensatory actions, perhaps in response to the pressure of time constraints, the difficulties associated with working with client resistance, contextual constraints and a sense of being lost in the treatment. These experiences appear to have triggered an attempt to take back control of the situation through the use of an overly structured therapeutic approach. Participants referred to the fact that they would often experience a need to change their collaborative stance to one that is more didactic, with frequent references made by the majority of participants to the sense of having to *"push" (Charlotte:284)* the client in treatment. Participants frequently appeared to be positioning themselves as 'in-charge' and all expressed experiencing elements of annoyance or frustration with their clients when they were unable or unwilling to engage. Such a change in approach frequently seemed to result in a breakdown of the use of core conditions such as therapist warmth, acceptance and unconditional positive regard leading to a crumbling therapeutic alliance between the participant and client. Despite the participants highlighting the difficulties that client resistance created in delivering successful therapy, little consideration was given to their own role in this resistance. Furthermore, there was a notable lack of consideration regarding the participant's counter-transference experiences that may be contributing to the adoption of an authoritative and demanding stance that appears to have been experienced as necessary by the participants.

3.3.1 Sub-Theme: Follow my lead

Many of the participants felt compelled to develop an authoritative stance in response to client's difficulties engaging with the CBT protocol. This is expressed by Mark:

***"we are kind of told by duty and by supervision that we shouldn't be kind of pushing patients into treatment or into doing strategies so you lay it out and it is the patient's choice whether they engage with it or not, with OCD because of the nature of what it is I think that rule sort of goes out the window a little bit and you do have to push people a little bit and convince them to get them to try something, that can be quite time consuming and take a lot of effort I think so these patients tend to be, second to PTSD patients, I find them the most challenging"* (*Mark:165*)**

Mark appears to be indicating that when it comes to OCD the expected collaborative therapeutic style can be legitimately disregarded even in the face of advice to the contrary from more senior clinicians *("we are kind of told by duty and by supervision that we shouldn't be kind of pushing patients")* highlighting the strength of Mark's perception that metaphorically *"pushing"* those with OCD in treatment is necessary. He appears to justify this adaptation of his therapeutic style because of the 'special' nature of OCD, which is experienced by Mark as different from other disorders *("with OCD because of the nature of what it is"),* requiring a more directive approach *("you do have to push people a little bit")*. Mark appears to deem it necessary to *"convince them to get them to try something"* and positions himself as being responsible for persuading the client to engage in therapy. Mark references that this process of convincing the client is *"quite time consuming"* leading him to experience OCD clients as one of the more challenging conditions that he treats. This controlling therapeutic style adopted by participants may have created an environment in which the client struggles to feel accepted and safe due to the goals for treatment seeming to be being imposed by the therapist rather than being arrived at collaboratively. This may significantly impact on the sense of mutual understanding between the client and therapist and hence the therapeutic relationship. In this case, little consideration appears to have been given to the potential subjective and objective counter-transference experiences that may be resulting in the participant's strong desire to adopt a controlling attitude when working with clients with OCD.

This sense of having to 'convince' and 'push' the client was highlighted by many of the participants interviewed. Isabella stated: *"it becomes a bit less collaborative and more of you telling them what to do essentially umm or feeding them what they could do" (Isabella:460).* The language used by Isabella in which she is *"feeding"* the client may highlight the potential power imbalance in the sense that she views the client as someone that needs to be kept alive through feeding them what she has to offer. The participant appears to be positioning herself in an authoritative stance while the client may be rendered a passive receiver. In line with this didactic stance in which the clinician attempts to impose a solution onto the client Rachel described the experience of working with the resistance of the client as a *"tug of war" (Rachel:991)* in which the therapist is trying to force the treatment in one direction while the client is resisting and pulling back against this. This sense of a tug of war happening between the client and

the therapist may lead to potential ruptures in the therapeutic relationship as the participant becomes embroiled in a dynamic in which they focus rigidly on the tools and techniques of the model while potentially missing the opportunity to validate the emotions that the client may be experiencing during therapy. This could result in difficulties in the dynamic if the client does not perceive the therapist as being able to understand, reflect and value their emotions.

It is notable that parallels may be drawn here between the experience of the participant's desire to adopt a didactic style and the nature of OCD intrusive thoughts and compulsions. For example, the dominating therapist may mirror the OCD *"bully" (Andy:102)* that 'convinces' the client into completing rituals and compulsions. In this way it could be argued that the participant is imposing the same force on the client as the OCD in terms of getting the client to do something. The participants also appeared to experience a need to focus on making the client aware of what the consequences of not engaging in therapy may be. This is exemplified by Ava: *"it is going to hurt like hell [participant laughing] but it is going to be so worth it and things are going to be more painful if we don't" (Ava:976)*. Ava's use of the words *"hurt", "hell"* and *"painful"* alludes to what may be awaiting the client if they continue to resist engaging in the treatment. This may be akin to what the client experiences when they feel compelled to undertake a compulsive act in the sense they may become convinced by the OCD that something terrible may happen if they do not give in to compulsions in response to intrusive thoughts. The language used here by the participant also does not leave the client with much sense of choice as it is somewhat directive and urges the client to engage in the solution the practitioner has deemed the only way rather than this being collaboratively decided upon. This sense of feeling the need to engage the client in this way may arise from the participant's experience of desperation at not being able to find a way in to help the client and potentially feeling a sense of threat when the treatment is not going to plan.

Demonstrating expert knowledge seemed to be at the forefront of the participant's minds when engaging in therapy with their clients, as demonstrated by Amelia:

"I think it is everything if a patient does not have trust in you and does not feel comfortable in your presence it is not going to do anything, well he might but it is not

going to feel the same it is going to be harder, so I think trust is essential because they need to trust that what you say and what you know you know is going to make a difference to their lives so that is very important" (Amelia:737)

Amelia is clearly conveying her perception of the need for the client to have *a priori "trust in you"* suggesting that there is an onus on the client to bring this trust to the relationship rather than it being built within the therapeutic relationship through the contributions of both parties. The phrase *"they need to trust that what you say and what you know"* suggests that she perceives the therapists' expertise in the treatment of OCD as the *"essential"* factor that enables the client to decide to participate in treatment. The impact of the therapist feeling a need to convey superior knowledge in the subject area in a bid to encourage engagement may have implications on the power dynamic within the therapeutic relationship in which the therapist appears to be positioning themselves as the 'expert' which may be damaging to the spirit of collaboration.

3.3.2 Sub-Theme: Plan. Plan. Plan.

Further to this sense of having to convince and persuade the client leading to a didactic approach it also appeared that many of the participants felt a greater need to plan and categorize the treatment into a rigid structure of lists and tasks.

"I think having a visual plan in place having all the things mapped out that if you fail this step then this is what you have to do instead, you can break it down even further and can go in for some examples, I think it is just that there are no manoeuvres that move away from it so it's this is your plan this is what you do if this is what happens then this is what you do, so you action plan it all out and I think that makes people feel secure because it is not ambiguous anymore it feels very set like this is what I need to do and if this happens then I'll do this and if that happens then I need to do this and I think that kind of increases adherence" (Mark:419)

Mark appears to feel a need to have a fixed *"visual plan"* to guide the treatment and have everything *"mapped out"*. It may be that Mark's desire to make sure there is a plan in place is a response to his own experience of becoming lost and trapped in the complexity of the symptoms leading to him becoming prescriptive regarding what steps the client should take *("if you fail this step then this is what you have to do instead")*.

The use of the language regarding failure *("if you fail")* suggests that Mark has some expectations of the client but assumes that these will not be met and so needs to develop a contingency plan. Furthermore, Mark seems keen to inform the client about what they *"have to do"* perhaps indicating a more instructive approach rather than presenting a choice to the client. Mark appears to see this plan as preventing *"manoeuvres that move away from it"* suggesting an attempt to force the client to engage with the *"action plan"*. This may have serious implications for the therapeutic alliance because the setting up of expectations and strict standards may demotivate the client, leading to potential drop-out from treatment. It appears that Mark perceives his imposed structure as containing for the client *("makes people feel secure").* However, it may also be providing some sense of containment for Mark owing to the use of the pronoun "I" when describing the plan (*"this is what I need to do and if this happens then I'll do this")* implying that Mark feels somewhat out of control in the therapy with the client and is attempting to reassure himself by imposing this control through an overly rigid approach. Once again this has implications for the therapeutic dynamic between the practitioner and client as an excessively planned session and a controlling stance may be perceived by the client as lacking in empathy and may not allow for the emotional validation of the client. This has implications for client resistance as attempting to 'change' a client who has not had their emotions validated may increase that client's desire to resist change, potentially leading to client drop-out. Once again, a consideration of the subjective and objective counter-transference experiences contributing to this need to excessively plan a session has been given little reflection by the participants.

3.3.3 Sub-Theme: Disintegrating Alliance

The consequence of adopting a more directive, rigid and controlling therapeutic stance appears to have an impact on the therapeutic alliance which is described by Rachel:

"I think sometimes it can feel like you are on one side of understanding and they are completely on the other whereas maybe with some other disorders you can kind of meet in the middle a bit more, whereas with some of those sort of thoughts and ideas are very very ingrained well I guess it is the same with other things but more commonly in OCD I have found that it can feel like you are on two sides of the bus

instead of understanding it together and I think that can impact on the therapeutic relationship" (Rachel: 696)

Rachel describes experiencing a gulf opening up between herself and the client in terms of their understanding of the problem. This is expressed as the participant finding herself at the opposing end to the client of a continuum of the conceptualisation of the problem *("it can feel like you are on one side of understanding and they are completely on the other").* Interestingly, Rachel experiences this uniquely when working with clients with OCD in which it is much more difficult to *"meet in the middle"*. Rachel expresses the view that a shifting of understanding from the client's perspective towards the participant's perspective regarding the problem is complicated by the *"very very ingrained"* nature of the thoughts which are harder to alter. Rachel perceives this as impacting on the collaboration within the therapeutic alliance during the journey of treatment *("you are on two sides of the bus instead of understanding it together").* It seems that Rachel perceives the client to be out of reach and that a shared understanding cannot be achieved, leading to a breakdown of the alliance. These behavioural reactions expressed by the participants appear to have had an impact on the therapeutic relationship, because rather than working towards mutually agreed goals the participant and client appear to be pulling in opposite directions.

3.4: Theme Four: Frustrated Practice

When the participants perceived their attempts at engaging the client in treatment to have been unsuccessful, they appeared to experience an emotional response which oscillated between self-doubt, anger and frustration towards the client. When clients did not adhere to the participant's plan of the 'right' way of doing things, participants experienced insecurity resulting in a feeling of dread when working with this client group. These emotional reactions on the part of the participant appeared to further impact on the therapeutic relationship as it was difficult to maintain a focus on the use of the core conditions such as empathy and unconditional positive regard when experiencing these affective states.

3.4.1 Sub-Theme: Not Enough

A number of clinicians negatively evaluated or criticised the therapy they had delivered to their clients with some blaming themselves for clients not engaging with treatment or

improving. A tendency for therapists to instinctively attribute difficulties encountered in therapy to their own perceived shortcomings was apparent, as exemplified by Amelia:

"I don't like it, I tend to be very hard on myself and think it is to do with me so rationally I know when I think back on a case or I discuss it with someone then I realise no, I have done everything I could it was more a matter of you know the choice not having been made, the client not being ready and of course sometimes as a therapist you don't get it right you know perhaps that person did not trust you enough things that you will never know because the patient does not come back to tell you" (Amelia: 838)

Amelia does acknowledge the contributions of both the client and herself in the therapeutic endeavour *("the client not being ready and of course sometimes as a therapist you don't get it right")*. Whilst Amelia does appear to make a concession here to the possibility that the stance and behaviours she engaged in during therapy may have contributed to the client's disengagement, this was not viewed through the lens of counter-transference and instead through a sense of doing things correctly or incorrectly *("you don't get it right")*. Amelia describes the impact on how she views herself and her clinical practice when a client disengages with the treatment process. She clearly places the responsibility for this disengagement onto herself *("it is to do with me")* and engages in self-criticism as a result of this *("very hard on myself")*. It appears the participant has become caught in her own 'vicious cycle' in which she is unable to challenge the negative appraisals of her practice leading to uncomfortable emotions *("I don't like it")*. Discussing this with another does appear to help with challenging her own thoughts regarding the disengagement *("I discuss it with someone then I realise no, I have done everything I could")* highlighting the importance of the opportunity for therapists to debrief and discuss difficult cases in clinical supervision. It seems however, that Amelia is left with a sense of uncertainty regarding what happened in the therapy that resulted in the disengagement and feels alone with this as it cannot be talked about with the client *("you will never know because the patient does not come back to tell you")*.

Some clinicians suggested that aspects of the therapy model itself facilitated negative judgements regarding their practice. For example, Rachel spoke of using the client's

ability to move up the ERP hierarchy as a marker of her own success and ability as a therapist:

"it is quite a quantifiable part of the therapy and I guess with that comes like you are measuring yourself like rating yourself against something I don't know what maybe their goals maybe like how well it went last time I think there is definitely something kind of almost judging yourself as the therapist as to how much you can encourage someone to do umm if that makes sense umm I don't know if it is just an IAPT thing" (Rachel:443)

Referring to the ERP aspect of treatment Rachel describes this as a *"quantifiable part of the therapy"* which she perceives creates an opportunity for an objective measure or *"rating"* on her clinical practice. There appears to be a sense of pressure being placed onto her to encourage clients to do more, presumably resulting in negative self-judgements if the participant is not able to do this. Rachel contextualises this as potentially being unique to the IAPT environment *("an IAPT thing")* which is a clinical setting that places a high value on objective measures and clinician's performance in terms of maintaining high recovery rate targets. It appears Rachel is indicating an external motivation for client engagement and improvement, such as pleasing a manager or supervisor. This sense of external monitoring and the potential for a supervisor to objectively judge her performance may enhance the potential for self-criticism and heighten the participant's desperation for the client to improve. This desperation being expressed by the participant resulting from client non-engagement may be driving a desire to adopt an overly didactic stance in therapy with consequences for the dynamic between therapist and client.

3.4.2 Sub-Theme: Internal Conflict

Some clinicians made seemingly contradictory statements specifically about the sense of wanting to 'push' clients in treatment. They would declare the need to adopt a more instructive approach, while simultaneously attempting to present the client with freedom and choice. This perhaps indicates a sense of wanting to conceal some elements both to themselves or perhaps even to the researcher of how they are interacting with the client. For example, Ava stated:

***"empowering them you know this is your choice this is totally your choice, you can either choose this option or you could choose this option and bringing back the rationale in that as well but really really validating that it is really tough but it is the only way" (Ava:1054*)**

Ava in this statement appears on the surface to want to be *"empowering*" the client through presenting them with a *"choice"* while simultaneously being very clear that engaging in treatment is actually the only option *("it is really tough but it is the only way")*. The concept that Ava is bestowing empowerment onto the client suggests she views the power as residing with her which she can choose to give to the client or not. It seems that a false choice is being presented because the implicit message is there is actually only one path that can be followed that will lead to recovery. Perhaps Ava may be concealing her own felt sense of power from herself and others through presenting this false choice to the client. This may have implications for the therapeutic alliance as there seems to be a lack of genuineness developing on the part of the participant which is known to be an important non-specific therapeutic factor within therapy and in the development of a strong therapeutic relationship (Mearns & Thorne, 2013).

3.4.3 Sub-Theme: Fleeing the client

The majority of clinicians interviewed described experiencing a sense of frustration when working with clients with OCD using a CBT approach, ultimately leading to a desire to disconnect. There appeared to be a sense that the participants felt unable to 'solve' the client's difficulties which was uncomfortable and led to a bubbling resentment towards them. At times this escalated into a feeling of anger, which one participant wished she could express physically *"I felt you know even though I wasn't his mum at times really angry and I just wanted to shake him which is something obviously as a therapist you can't do" (Amelia:420)*. Amelia's sense of wanting to "shake" her client highlights the level of frustration that was evoked in this participant. These powerful emotions may suggest a potential counter-transference reaction being triggered in the therapist by the client's resistance to treatment; however, this does not seem to have been acknowledged. The use of the word "shake" captures an experience of the participant wanting to awaken something within the client to attempt to get them to engage in the process and the sense of annoyance that is experienced when this is not possible. The participant appears to be expressing a sense of being threatened by the

client's resistance and comes to view this as something that is preventing them from doing their job as a therapist. This may have implications for the therapeutic relationship as there is the potential for an invalidating and even threatening environment to be established.

These common experiences of frustration and anger amongst participants triggered by client resistance appeared on occasion to result in a desire to create distance between themselves and the client by placing responsibility back onto the client. This was exemplified by Andy:

"I don't actually have OCD so I can you know sympathise with your situation and I can see and imagine how difficult it is but I don't need to do these things and I can't do them for you umm and it really is you who needs to learn by doing umm and experiencing" (Andy: 639)

Andy clearly wants to distinguish himself from the client *("I don't actually have OCD"; "I don't need to do these things")* however he also seems to be expressing a sharing of emotions with the client as he references being able to *"sympathise"* as opposed to empathise with the clients experience. Sympathising would suggest more emotional closeness as this term is ordinarily used to refer to being able to understand and share in the feelings of another. This could suggest that while Andy may actually be sharing in some of the same unpleasant emotions as the client, he responds to this by reasserting his position as different to that of the client *("I can't do them for you and it really is you who needs to learn by doing")* thereby distancing himself from the problematic relationship and uncomfortable emotions.

This unpleasant emotional experience of frustration with clients led in some cases to a sense of wanting to avoid working with clients with OCD as expressed by Mark:

"I probably yeah I don't look forward to those sessions, I find them more demanding, more taxing umm I wish that they would DNA more" (Mark: 181)

Mark highlights a sense of negatively viewing his sessions with OCD clients who are not engaging due to the perceived higher level of demand of this client group. The use

of the word *"taxing"* evokes the sense of the participant being burdened and feeling under pressure, leading to him wanting to disengage from the therapeutic process and a desire for his clients to do the same *("I wish that they would DNA more")*. Therapists may become avoidant of clients they feel are beyond their ability and are requiring significant effort to work with. It appears that tension may arise in the therapeutic dynamic when the client does not meet the therapist's expectations leading to both client and therapist wanting the relationship to end which could have considerable implications for the treatment outcome through the rupture in the therapeutic relationship.

Findings Summary

The aim of this study was to explore high-intensity therapists experience of delivering individual CBT to clients with OCD. The analysis demonstrated that the participants' experienced OCD as a complex condition and struggled with the clients' resistance to the therapy techniques and the presence of contextual constraints. Such difficulties appeared to lead to a sense of desperately attempting to regain control of the treatment and consequently the adoption of a more directive and authoritative stance. Further to this, participants frequently described an increasing desire to heighten the amount of order and structure that was present in the therapy sessions if difficulties with client engagement were encountered. The impact of this therapeutic style appeared to be a lack of collaboration between the participant and client and a disintegrating therapeutic alliance resulting in the therapist and client moving further and further apart from one another. A notable lack of reflection was apparent regarding the therapist's own contribution and response to the interpersonal processes and impasses occurring in the therapeutic relationship.

4.0 Discussion

Within the literature base, the non-specific factor that has received the greatest attention across all therapeutic modalities is the therapeutic relationship (Ilardi & Craighead, 1994). Within the context of a CBT framework the therapeutic relationship has traditionally been de-emphasised and viewed as a necessary but not sufficient aspect of treatment which is important only insofar as it enables the client to engage with specific CBT techniques (Gilbert & Leahy, 2007; Westbrook, et al., 2011). In recent years, however, interest in the role of the therapeutic relationship within CBT has increased, with greater emphasis being placed on the alliance and clinicians and researchers becoming more open to the consideration of the traditionally psychodynamic concepts of transference and counter-transference (Cartwright, 2011; Leahy, 2008) and the importance of CBT therapists' knowledge of these concepts (Cartwright, 2011). A growing appreciation of these concepts within cognitive therapy may be related to research indicating counter-transference behaviours can negatively impact on therapeutic outcomes (Martin, Garske, & Davis, 2000). The findings of this study support a need for a greater focus on the therapeutic relationship and on transference and counter-transference within a cognitive framework, as a means of enabling greater client engagement with CBT for OCD.

The findings outlined in this study suggest that honing cognitive therapists ability to become aware of and use their own subjective reactions to understand their clients problematic interpersonal difficulties more deeply and to become aware of the ways in which they themselves may contribute to the therapeutic impasse through their counter-transference, may be of benefit in order to prevent negative therapy interfering consequences. Therefore, rather than therapists viewing 'client resistance' as an impediment to be overcome, it may instead be viewed as a rich font of information regarding the clients pattern of relating. An exploration of these relational patterns can be used to strengthen the therapeutic relationship and ultimately enable the clinician to be in a better position to implement the CBT techniques that have been shown to be effective in aiding those with OCD. The themes identified in the present analysis appeared to impact on the therapeutic relationship in a variety of ways. Each major theme will now be explored in light of previous research and highlighting, where

appropriate, the potential impact of each theme on the development of the therapeutic relationship.

4.1.1 Drowning in the Complexity

The experience of the participants in this study appeared to be one of feeling lost in the complexity of the treatment and the condition as a result of its heterogeneity, the presence of co-morbid conditions and a perceived lack of sufficient training. These concerns appeared to result in the participant wanting to keep a distance from the client and remain focused on therapeutic tools and techniques or, as Rachel described it, *"the CBT world*" (Rachel: 988). This withholding may have implications for the therapeutic bond and impacted on the sense of collaboration and mutual understanding between therapist and client, ultimately heightening the likelihood of ruptures to the therapeutic relationship. The extent to which the participants' own subjective and objective counter-transference may be contributing to the experience of feeling lost in the complexity of the symptoms was rarely reflected upon by those interviewed for this study. This lack of reflection on the possibility of counter-transference enactments may have implications in increasing the likelihood of client disengagement if these are not appropriately addressed, even within the context of cognitive framework.

Many clinicians in this study referred to OCD as a 'complex' and 'ingrained' mental health problem. This description accords with previous research exploring psychological wellbeing practitioners' perceptions of OCD in which participants similarly described the condition as requiring *"undoing or deep-level work"* (Gellatly et al., 2017, p5.). The perceived complexity of the condition amongst those interviewed for this study appeared to stem from the client exhibiting multiple different obsessions and compulsions, which is common in those with OCD (Sookman, Abramowitz, Calamari, Wilhelm & McKay, 2005). The challenges of a heterogeneous symptom profile were also noted by psychological wellbeing practitioners undertaking low-intensity CBT for OCD (Gellatly et al., 2017), with those clinicians stating the importance of being able to tailor the intervention to the client's personal needs (Gellatly et al., 2017). This finding tallies with previous research indicating that the heterogeneity of internal and external stimuli triggering intrusive thoughts and corresponding rituals requires a thorough case conceptualisation and the tailoring of

cognitive strategies and ERP interventions to the idiosyncratic needs of the client (Sookman et al., 2005). The findings of this study indicate that therapists may find the varying symptom profile of an individual with OCD a challenge to manage in therapy, suggesting improved training in OCD sub-type identification may be warranted.

In particular, several participants expressed difficulties engaging in treatment with clients exhibiting religious intrusions, otherwise known as scrupulosity (Buchholz, Abramowitz, Riemann, Reuman, Blakey, Leonard & Thompson, 2019). Individuals with this sub-type of OCD may have obsessions of having committed sacrilegious acts (e.g. blasphemous thoughts) and may engage in rituals such as praying in order to neutralize such thoughts to relieve their distress (Buchholz et al., 2019). The predominant challenge expressed by the participants when working with clients with this sub-type of OCD was a lack of knowledge and understanding of the client's religious practices and identifying what would fall into 'normal' behaviour in that religion and what may represent a compulsion. Research has indicated that mental health professionals may pathologize religious behaviour that they are less familiar with (Post & Wade, 2009). Therefore, allowing therapists to increase their understanding of clients' religious faith and providing time to reflect on the impact of their own views regarding religion and spirituality, is important. A need for awareness of how to develop an ERP hierarchy incorporating exposure tasks that are sensitive to a client's religious beliefs is vital in order to enable the individual to engage in the treatment but also to engage in their religion in beneficial ways (Buchholz et al., 2019). As such, the findings derived from this study and from previous research suggest it may be appropriate for the therapist to liaise with a religious/spiritual practitioner relevant to the client's religion in order to increase their understanding and knowledge of the religion (Buchholz et al., 2019). An ability to work sensitively and flexibly with the religious faith of the client is a vital component of a therapists' repertoire of skills and is needed in order to uphold the professional practice standards of counselling psychology which advocates *"anti-discriminatory practice appropriate to the pluralistic nature of society today"* (BPS, 2005, p.2).

The presence of psychological co-morbidity was noted by many participants as adding to the complexity of working with this condition. OCD is commonly co-morbid with other psychological problems including depression, social phobia, panic, eating

disorders and personality disorders (Stekette, Eisen, Dyck, Warshaw & Rasmussen, 1999). The presence of psychological co-morbidity has been shown to increase drop-out rates and negatively impact on outcomes in CBT for OCD. For example, the presence of co-morbid generalized anxiety disorder (GAD) with OCD predicted treatment dropout (Stekette et al., 2001) and co-morbid PTSD resulted in poorer Y-BOCS scores at the end of treatment (Gershuny et al., 2002). The co-morbidity detected by the participants in the present study commonly heighten the participants' sense of being lost in the treatment. This finding concurs with previous research indicating that clinicians frequently endorsed the presence of co-morbidity as interfering with treatment progress within CBT for OCD (Jacobson et al., 2016). Participants frequently reported the presence of childhood trauma in clients. This concurs with research in this area, which has indicated a higher level of childhood physical, emotional, and sexual abuse in individuals diagnosed with OCD compared to controls (Lochner et al., 2002). The experience of clinicians encountering a history of physical or sexual abuse in CBT treatment for OCD has previously been reported with the presence of such trauma being endorsed by clinicians as a perceived barrier to effective treatment (Jacobson et al., 2016). Within the present study, the presence of co-morbidity appeared to create difficulties for participants in terms of identifying what needed to be worked on in therapy in addition to problems with client engagement in ERP tasks due to problems with client emotional regulation. These findings suggest that a comprehensive assessment of co-morbid psycho-pathology and the consideration of the impact of these conditions on the development of exposure hierarchies and completing exposure tasks should be completed by clinicians in order to facilitate engagement, which previous research has found to be beneficial (Carmin, Wiegartz & Wu, 2005).

The difficulties experienced by the clinicians in managing co-morbid psychological problems points to a wider problem of the categorisation of mental health diagnosis in the DSM-V (APA, 2013), which suggests that each diagnosis is a distinct and separate entity. However, this conceptualisation has been challenged with research indicating mental health problems represent multidimensional phenomena made up of a complex combination of multiple psychological issues (Clark, Cuthbert, Lewis-Fernandez, Narrow & Reed, 2017). For this reason, many individuals can meet the criteria for multiple different diagnoses (Kessler, McGonagle, Zhao, Nelson, Hughes, Eshleman & Kedler, 1994). However, within the current health care system in the UK, the use of the

DSM-V is the predominant means of discussing and identifying an individual's difficulties. This has important ramifications as it determines how clinicians approach their clients and determines the treatment provided (Clark et al., 2017). Counselling psychologists advocate to *"not assume the automatic superiority of any one way of experiencing, feeling, valuing and knowing*" (BPS, 2005, p.2.) and seek to *"engage with the subjectivity and inter-subjectivity"* (BPS, 2005, p.1) of the client. While the medical model predominates, particularly within NHS practice, counselling psychologists advocate for a critique of diagnostic categorisation and a reflective and questioning stance to be adopted in its application. The findings of this study, which highlights the clinical problems of attempting to ascribe one diagnosis and only treating the client on the basis of this diagnosis, suggest that a critical approach to the labelling and categorisation of psychological distress may be a useful concept across the mental health professions in order to allow the client to be viewed more holistically and focus on prioritising their subjective experience.

The management of the heterogeneity of OCD in combination with the high incidence of co-morbidity, did not appear to be an aspect of clinical practice that the participants felt had been adequately addressed during their training. Several participants cited the lack of relevant clinical examples and the focus on the theoretical aspect of the treatment of OCD as leaving them unprepared for the reality of working with this condition. This sentiment concurs with previous qualitative research exploring the experiences of primary mental health care workers delivering low-intensity CBT within an IAPT setting. This study showed that Primary Mental Health Care Workers (PMHCW's) reported that the clinical training they had received was experienced as rushed and pressurised and resulted in a sense of being unprepared for the clinical work they were being asked to undertake (Rizq, Hewey, Salvo, Spencer, Varnasseri & Whitfield, 2010). Therefore, the findings of the present study suggest a need for specific training regarding OCD to incorporate information on how a clinician may best manage the heterogeneity of this condition and the frequent presence of other co-morbid conditions when these are encountered in clinical practice.

4.1.2 Boxed In and Shut Out

The clinicians interviewed described several client factors that they perceived to act as barriers and constraints on the clinical effectiveness and progress of the CBT treatment they were delivering, leaving them with sense of being shut out. The first of these were the client's difficulties with disclosing their intrusive thoughts and compulsions. These findings concur with quantitative research indicating that clients with OCD are reluctant to disclose intrusive thoughts due to fear of judgement from others (Rachman, 2007). Research has also demonstrated that shame regarding intrusive OCD thoughts leads to difficulties with disclosure (Glazier, Wetterneck, Singh & Williams, 2015) and subjective accounts of clients receiving CBT for OCD via computer reported that clients preferred the enhanced privacy this format afforded as they felt more able and willing to disclose intrusive thoughts that they would not have done had the therapy been face-to-face (Knopp-Hoffer et al., 2016). In addition to issues of non-disclosure a further difficulty that participants reported experiencing was the client's reluctance to complete the behavioural aspect of the treatment. This tallies with previous quantitative research regarding clinicians' experience of CBT for OCD in which the client's resistance to complete work between session was frequently endorsed as a barrier to treatment progress (Jacobson et al., 2016). It is well documented within the literature that clients may hold fears regarding completing ERP work (Mancebo, Eisen, Sibrava, Dyck, Rasmussen, 2011) or may be ambivalent about change (Simpson & Zuckoff, 2011), leading to a lack of engagement with the therapy as a whole. However, whilst the difficulties of client resistance were acknowledged by participants in this study, it appeared that little attention was given to the participants' own contribution to this resistance. A tendency to label clients as 'resistant' and 'unwilling to engage' appeared to block exploration regarding the factors contributing to resistance in therapy and for participants to view this as not only a client variable but also a product of the therapist's approach. Whilst the therapeutic relationship was acknowledged and considered by the participants interviewed, there appeared to be a notable absence of reflection regarding the extent to which the therapeutic dynamic may be contributing to client resistance in therapy.

Participants reported a number of contextual barriers, which they perceived to impact on the treatment when working with clients with OCD using CBT. Several clinicians

referred to the time pressure they experienced within an NHS IAPT setting leaving them with limited space for reflection on their practice. Several clinicians reported requiring more time to complete a formulation and conceptualisation with the client, leaving limited time to complete exposure work. High workloads and time pressure due to the strict limits placed on the number of sessions per client is known to be a feature of IAPT services (Chinn, Abraham, Burke, & Davis, 2014). The lack of time created particular difficulties with completing '*therapist-directed/therapist-conducted'* in-vivo ERP when working in an NHS service. Indeed, only one participant reported completing such a form of ERP when working in an IAPT context, due to the contextual and practical barriers that they faced in being able to leave the therapy room with the client in order to conduct ERP. This finding resonates with previous quantitative research in which clinicians stated they more frequently employed out-of-session *'therapist-directed/self-conducted ERP'* (Jacobson et al., 2016).

An additional constraint reported by the participants was the client's social and family environment. Family accommodation refers to alterations in family members' behaviour in order to attempt to reduce distress associated with OCD symptoms e.g. checking appliances or providing verbal reassurance for their family member with OCD (Calvocoressi et al., 1995). Some participants reported that accommodations made by the family or friends in the client's home environment maintained OCD symptoms and hampered progress in therapy. This finding concurs with previous quantitative research into clinicians' experience of delivering CBT for OCD in which 80% of clinicians endorsed the reinforcement of client symptoms through the social environment as interfering and acting as a barrier to successful treatment (Jacobson et al., 2016). Empirical evidence suggests that greater family accommodation results in heightened OCD symptoms, increased functional impairment and poorer outcomes (Amir, Freshman & Foa, 2000). In addition, accommodation over the long-term can lead to increased distress for the family members themselves (Calvocoressi et al., 1995). Further to this, clinicians indicated that critical or unsupportive responses by family members to the treatment acted as a barrier to progress, in particular if this criticism was directed towards the therapists themselves. This finding is in line with previous research, which indicated over half of clinicians endorsed an unsupportive response from family to treatment as being a barrier (Jacobson et al., 2016). Studies have indicated that clients' perception of family members as critical and angry and the

presence of negative feelings in the household predicted poorer treatment outcomes and higher relapse rates (Thompson-Hollands, Edson, Tompson & Comer, 2014). Despite the difficulties associated with family involvement, it was rare for participants interviewed for this study to directly involve family members in treatment plans. These finding suggests that family members should be involved in treatment and informed of the behaviours, which may diminish the impact of the treatment (e.g. participating in the clients rituals) in order to enhance engagement and effectiveness as research has suggested that 'family-inclusive treatments' improve treatment outcomes for OCD (Thompson-Hollands et al., 2014).

Many clinicians spoke of the limitations of standard CBT for OCD causing a sense of feeling 'boxed in' by the model. Most clinicians freely offered the additional techniques they employed to supplement the model in order to encourage engagement. Attempting to increase clients' distress tolerance was one way in which clinicians reported supplementing the standard CBT protocol in order to aid clients' engagement. Distress tolerance has been defined as *"an individual's perception of his or her ability to experience and withstand negative emotions"* (Michel, Rowa, Young & McCabe, 2016, p. 94). It is an emotional regulation construct and recent studies have concluded that lower distress tolerance is associated with obsessions in a non-clinical sample (Cougle, Timpano & Goetz, 2012) and has been associated with higher levels of anxiety following tasks designed to trigger intrusive thoughts (Cougle et al., 2012). Recent research has indicated that distress tolerance is not only associated with OCD but with a range of other anxiety disorders including GAD and social anxiety (Laposa, Collimore, Hawley & Rector, 2015). As such it is thought it may represent a trans-diagnostic vulnerability factor for a range of anxiety psychopathologies (McHugh, Kertz, Weiss, Baskin-Sommers, Hearon & Bjorgvinsson, 2014). This may represent an important advance in the literature because the identification of factors common to several of the anxiety disorders may indicate a target for treatment interventions. The participants' experience of having to supplement the standard CBT protocol with distress tolerance strategies resonates with previous quantitative research indicating that clinicians perceive a significant limitation of the CBT model for OCD to be its *"insufficient focus on affect tolerance/regulation"* (Jacobson et al., 2016, p.85).

Further to distress tolerance work, several participants spoke about their use of motivational techniques *("I have had to dip into using maybe motivational interviewing", Ella:335)* to encourage engagement in exposure tasks. This concurs with previous quantitative research suggesting that over half of clinicians endorsed using motivational enhancement in their clinical practice when delivering CBT for OCD (Jacobson et al., 2016) in response to perceived minimal client motivation for treatment at the outset and perceived decreases in client motivation as treatment progresses (Jacobson et al., 2016). Due to the high dropout rate observed in CBT for OCD, motivational interviewing (MI) has been explored as a possible adjunct to the standard protocol, with mixed outcomes (Simpson, Zuckoff, Page, Franklin & Foa, 2008; Simpson et al., 2010). While a detailed exploration of the motivational techniques used by clinicians in this study was not undertaken it would appear that strategies consistent with an MI approach were being employed with some success. For example, several clinicians expressed the importance they placed on eliciting the discrepancy between the client's values and goals and their current circumstances in an attempt to utilise information regarding the client's idiosyncratic values to design exposure tasks that would increase motivation and adherence. Further research is needed to explore the conditions under which motivational interviewing may be used to enhance the standard CBT protocol.

In addition to specific therapeutic techniques, several participants highlighted their use of non-specific therapeutic factors as a means of attempting to enhance engagement and resist the sense of being boxed in and shut out. The majority of participants spoke of the importance of developing a credible explanation for the client's difficulties through a detailed formulation and sought to provide a rationale, in particular for ERP, early on in the treatment process. The provision of a credible rationale, across any psychotherapeutic intervention, is deemed to be a non-specific therapeutic factor and is important to the extent that it fosters a collaborative relationship between therapist and client and installs hope and positive expectancies in the client (Shapiro, 1981). Participants did appear to be aware of the importance of the therapeutic relationship and spoke of certain facilitative conditions such as warmth and empathy as being important in the creation of a strong therapeutic bond. Participants spoke of the use of humour as a means of attempting to increase collaboration, enhance the therapeutic alliance and thereby increase adherence, in particular to ERP tasks. Research has indicated that the

use of humour in therapy allows for clients to alter their perspective on their own cognitions and is a useful tool for developing the therapeutic relationship and reducing resistance to treatment (Lynch, 2002).

However, whilst participants acknowledged the importance of the therapeutic relationship, the process issues occurring in this relationship, in addition to the facets of the model itself, that may have contributed to clients' unwillingness to engage, appear to have received little reflection by the participants. The cognitive-behavioural approach to therapy is based upon the 'rational principle', which is the assumption that individuals will be motivated to change their beliefs to be consistent with logic and reason (Leahy, 2001). CBT believes that an individual looks at the costs and benefits of their beliefs, examines the evidence against their 'distorted' thoughts and then acts to change (Leahy, 2001). This model, however, has been criticised, because for those who may already perceive themselves as being 'defective' the focus on distorted thinking may be interpreted as invalidating (Leahy, 2001). In this sense, the model itself may be a cause for the client to leave therapy if the techniques of CBT are applied in haste and without first adequately acknowledging and validating the emotional distress of the client. In essence, attempting to change a client who has not first felt validated often results in the client trying to prove that they cannot change (Leahy, 2001). It is possible that therapists' heightened focus on specific therapeutic techniques at the expense of the client's emotions may result in therapeutic interventions being viewed by the client as critical or even hostile and the client may begin to attempt to elicit emotional validation from the therapist through a variety of therapy-interfering strategies (Leahy, 2001). In this sense, an unhelpful dynamic is created in which the therapist is holding onto the model and its techniques while the client refuses to engage with it due to a lack of emotional validation, resulting in what Rachel describes as a *'tug of war' (Rachel: 1003).* This would have clear implications for the therapeutic bond and collaborative relationship whilst in therapy.

The findings of this study suggest that therapists may consider how to first accept the client's need for emotional validation prior to any attempts at change or presenting therapeutic techniques. It order to aid this process, the therapist engaging in their own identification and challenging of possible unhelpful thoughts regarding the client's need for emotional validation may allow the therapist's own emotions when faced with

resistance, such as frustration and anger, to be appeased (Leahy, 2001). Lastly, the therapist may acknowledge that the model itself is in some ways invalidating as challenging certain thought 'distortions' may be perceived as dismissive and implies that the client's way of seeing the world is wrong. Voicing this in a manner that conveys that there are many ways of thinking, each with its own truth, could aid the client in feeling his or her emotions and thoughts are understood, thereby strengthening the therapeutic bond and increasing the credibility of the therapy.

4.1.3 Desperately Seeking Control

Participants appeared to experience a desire for all eventualities to have an action plan and appeared more comfortable when a strong emphasis was placed on structure. For example, one participant declared he must have *"a visual plan in place having all the things mapped out that if you fail this step then this is what you have to do"(Mark: 423).* This preference for a structured approach when working with OCD clients resonates with previous research of the experiences of low-intensity practitioners delivering CBT for OCD who declared that the structured nature of the intervention allowed the *"fear that people might have in working with OCD"* to be removed (Gellatly et al., 2017, pg 7). The impact of an overly planned approach to therapy has recently been investigated. Certain dimensions and attitudes within therapists delivering CBT to those with depression were ascertained, including dimensions of 'Concern over mistakes'; 'High standards for others'; 'Need for approval', 'Organisation'; 'Planfulness' (sic); 'Rumination' and 'Striving for excellence' (Presley, Jones & Newton, 2017). The presence of these dimensions were explored in relation to client outcome scores for both depression and anxiety, and client drop-out rates (Presley, Jones & Newton, 2017). Results indicated that the dimension 'high standards for others' was associated with poorer outcomes on a depression measure, PHQ-9 (Kroenke, Spitzer, & Williams, 2001), while the dimensions 'Concern Over Mistakes' and 'Planfulness' (sic) were associated with poorer outcomes on a measure for anxiety, GAD-7 (Spitzer, Kroenke, Williams & Lowe, 2006). Furthermore, the dimension 'High standards for others' and 'Rumination' were correlated with higher client drop-out rates (Presely, Jones & Newton, 2017). This research indicated that better treatment outcomes are associated with therapists who have less fear about making mistakes and who do not overly plan their therapeutic sessions (Presley, Jones & Newton, 2017).

Furthermore, as indicated through previous research, clients with OCD may themselves exhibit dimensions including 'planfulness' (sic) in a bid to cope with uncertainty (Presely, Jones & Newton, 2017), and to control ones' environment and avoid mistakes (Rheaume, Freeston, Duga, Letarte & Ladoucer, 1995). Therefore, therapists who also engage in high levels of 'planfulness' (sic) may inadvertently be colluding with this aspect of the client's presentation, thus reinforcing the difficulty. Therefore, the attitudes and behaviours that appeared to be exhibited by participants in this study may inadvertently weaken the therapeutic relationship and reduce the impact of therapy. Furthermore, research indicates that an open and flexible stance in therapy is more beneficial than a controlling or rigid stance, which positions the therapist as taking charge in the relationship (Hovarth, 2011).

Further to the participants' experience of feeling compelled to adopt a more rigid and highly planned approach, the participants appeared to adopt high expectations of both themselves and their clients, illustrated by their desire to 'push' the client when doing ERP tasks. It seems that the challenge of engaging clients may have resulted in an over-zealous therapeutic style in which the participant felt responsible for persuading the client to engage. Such an approach may result in ruptures in the therapeutic relationship if these high expectations are not met, potentially causing client demotivation and dropout. Within the CBT model a key component of the therapeutic relationship is that of therapeutic collaboration (Westbrook et al., 2011) involving therapist and client agreement on the development of goals for treatment, the design of experiential exercises, and the direction of treatment (Beck, Rush, Shaw & Emry, 1979). A didactic and authoritative therapeutic style, coupled with placing high expectations on clients, may weaken this sense of collaboration and potentially result in impatience and a lack of empathy for the client (Leahy, 2001). This would have implications for treatment, as a weak therapeutic alliance has been shown to predict poor outcomes in CBT for OCD (Vogel et al., 2006).

4.1.4 Frustrated Practice

Completing CBT with those with OCD appeared to have an emotional impact on the participants. Many referred to feeling frustrated and appeared to be chastising themselves for their work. The present findings indicating participants experience of a

level of frustration and anger towards their clients concurs with previous quantitative research in the same field. Previous research indicated that negative feelings towards clients and feelings of frustration with a lack of treatment progress were frequently cited by therapists and were perceived to hamper successful treatment (Jacobson et al., 2016). Indeed, lower therapist confidence and reduced enjoyment of delivering therapy is known to be predictive of reduced clinical effectiveness (Heionoen, Lindfors, Laaksonen, & Knept, 2012). Furthermore, a lack of therapist confidence around engaging with this client group has been noted in previous research (Gellatly et al., 2017).

Concepts of subjective and objective counter-transference may be applicable to interpreting the reported emotional experiences of the participants in this study. The self-doubt and frustration that seemed to be frequently experienced by the participants interviewed in this study may be as a result of their subjective counter-transference (i.e. their own beliefs about themselves and others in relationships which has a resulting impact on their perceptions of the client in treatment and their actions in the therapeutic relationship) (Cartwright, 2011). In addition, clients with OCD may evoke certain objective counter-transference responses from the therapists (i.e. the therapist reactions that are provoked by the clients style of relating) (Cartwright, 2011), which if not recognized may lead the therapist to act in ways that rupture the therapeutic relationship and are counter-productive to successful treatment. For example, the feelings of helplessness and sense of being lost and trapped reported by the participants in this study appear to have resulted in the participants becoming overly technique focused, controlling and didactic in their approach, leading to a sense of conflict in their treatment approach and a wish to avoid working with such clients in the future.

The need to acknowledge and address the concepts of transference and counter-transference that may arise in clinical work even within a CBT context has been noted by previous qualitative work exploring the experience of primary care mental health workers in an IAPT service (Rizq et al., 2010). This study reported that the participants articulated a need to have more opportunity to discuss the concepts of transference and counter-transference, along with the emotional impact that working with clients had on them. They reported that these concepts were rarely emphasised, or even raised, in their training or in their clinical supervision (Rizq et al., 2010). In addition to this, a recent

study indicated that only two fifths of a cohort of cognitive therapists in training received supervision regarding their counter-transference experiences despite expressing their difficulties in managing their emotional responses to clients (Cartwright, Rhodes, King, & Shires, 2014).

4.2 Implications for Counselling Psychology Clinical Practice, Training and Organisational Policy

A key theoretical and clinical implication of this research is the reconsideration of the importance of the therapeutic relationship in the delivery of CBT, in particular when treating OCD with its high dropout rate. While the significance of the therapeutic relationship is accepted across many forms of psychotherapy, CBT has traditionally placed more emphasis on the utilisation and execution of specific therapeutic techniques (Gilbert & Leahy, 2007). However, there has been a growing interest in the therapeutic relationship within cognitive therapy in recent years (Leahy, 2008; Cartwright, 2011) and an acknowledgement that in order to ensure a good alliance is developed, CBT therapists need to be able to recognise, understand and manage their own responses to clients (Gelso & Hayes, 2007). Such an assertion is supported by research indicating that a lack of therapist understanding and insight regarding the interpersonal processes involved in a therapeutic relationship can lead to difficulties in therapy (Young et al., 2003). The translation of the terms transference and counter-transference into a cognitive behavioural framework, in order to enhance the ability of the CBT therapist to attend to such issues within the therapeutic relationship, has taken place (Miranda & Andersen, 2007). Research has shown that counter-transference behaviours can interfere with the therapeutic relationship due to these behaviours meeting the needs of the therapist as opposed to the client (Ligiero & Gelso, 2002). Indeed from the findings and analysis presented in this research project, it would appear that working with OCD using a CBT approach, particularly in a short-term context, leads to the activation of certain emotions and behaviours in participants, seemingly resulting in negative therapy-interfering consequences which may be implicated in client drop-out or disengagement. Therefore, facilitating the ability of high-intensity CBT therapists to actively engage with concepts of transference and counter-transference and cultivate a stance of on-going awareness that allows them to recognise and collaboratively explore the interpersonal cycles occurring in the relationship with their clients may result in

improved treatment outcomes and rates of adherence (Leahy, 2001; Cartwright, 2011). A core competency of counselling psychologists, according to the HCPC is an ability to *"be able to critically reflect on the use of self in the therapeutic process"* (HCPC, 2015, p.12) and the profession developed from thinkers who identified the subjectivity of the self and others as fundamental to psychology (Larson, Brooks & Del Loewenthal, 2012). Furthermore the counselling psychology profession is underpinned by a commitment to reflective practice and use of self-knowledge (Lane & Corrie, 2006). As such, counselling psychologists are in a strong position to facilitate CBT therapists becoming aware of their own subjective feelings as a means of understanding what is occurring within the interaction between therapist and client, ultimately allowing ruptures in the therapeutic alliance to be repaired and enabling growth and change. Input and guidance from counselling psychologists, particularly for CBT therapists working in an environment such as an NHS IAPT service in which there is little time available to reflect on the development of the therapeutic relationship, would be beneficial. Highlighting the importance of the therapeutic relationship is in line with the fundamental values of the counselling psychology profession, which is grounded in the *"primacy of the counselling or psychotherapeutic relationship"* (BPS, 2005, p1).

4.2.1 Implications for High-Intensity CBT Therapist Training

A key implication of the findings of this study relates to the training of high-intensity CBT therapists. Recent research has indicated that trainee therapists receive little support and input into understanding and utilising the concepts of counter-transference and transference within their supervisory relationships (Bucky, Marques, Daly, Alley, & Karp, 2010; Cartwright, Rhodes & Shires, 2014). Furthermore trainee therapists utilising a cognitive therapy approach have stated that they would value support in developing an ability to identify their counter-transference responses along with gaining a deeper theoretical understanding of this concept (Cartwright, Rhodes & Shires, 2014). The findings of the present research project support the growing awareness of the increased need both for CBT therapist trainees and those delivering CBT training programmes to address the potential impact of the triggering of subjective and objective counter-transference responses within the therapeutic relationship. The development of a reflective stance and the engagement in self-reflection has been stated to be a core purpose of psychotherapy training (Skovholt & Rønnestad, 1992) and its benefits have

been demonstrated in adult learning (Kemmis & McTaggart, 2000) and the development of professional expertise (Schon, 1983). Self-reflection can be defined as *"a metacognitive skill, which encompasses the observation, interpretation and evaluation of one's own thoughts, emotions and actions, and their outcomes"* (Bennet-Levy, 2006, p.60). Factors which are thought to enhance therapist self-reflection include reflective writing, a Socratic style of supervision and personal therapy (Bennet-Levy, 2006). Therefore, encouraging CBT trainee self-reflection and potential identification of the triggering of the counter-transference responses that may impact on therapy enables the advancement of their therapeutic competence (Bennet-Levy, 2006).

Whilst cognitive therapy training programmes have not traditionally incorporated personally focused work, a paradigm known as 'Self-Practice-Self-Reflection' (SP/SR) (Bennett-Levy, 2001), has been investigated as form of experiential learning and has been shown to increase therapeutic skills and enhance self-development (Gale & Schroder, 2014). SP/SR involves the trainee practicing CBT techniques on themselves (self-practice) and reflecting on the outcome and experience of this (self-reflection). Incorporating self-practice techniques specifically related to heightening the trainees understanding of their subjective counter-transference responses has been suggested (Leahy, 2001). For example, the use of the 'Therapists Schema Questionnaire' allows for the identification of a trainee's core beliefs, schema and assumptions and can be used as a starting point for reflection on the potential impact of these upon the interpersonal processes occurring in the therapy between practitioner and client. The findings of the present study indicate that the routine incorporation of such measures when training CBT therapists who are working with clients with OCD, may create an opportunity to discuss the impact of unhelpful behavioural strategies arising from the counter-transference and the opportunity to reflect on alternative strategies that may enhance rather than diminish engagement with CBT for OCD.

Owing to the profession of counselling psychology being grounded in humanistic values which emphasises self-knowledge, self-awareness and openness to experience (Lane & Corrie, 2006), counselling psychologists are uniquely well-positioned to provide training in this area, both to fellow counselling psychology students and to other allied mental healthcare professionals such as CBT therapists. Furthermore, counselling psychologists are well placed to take a lead in incorporating opportunities

for enhancing trainees understanding of their subjective reactions and internal experience within the curriculum of training programmes for all mental healthcare professionals who will be utilising CBT in their clinical practice. Counselling psychology training programmes routinely include experiential learning and self-reflection through log books, journals and personal development groups in which trainees are invited to develop an awareness of the impact of their own behaviour on others (Davidson-Arad, Stange, Wilson & Pinhassi, 2002). Therefore such programmes may act as models for the inclusion of similar teaching and training methods into CBT therapist training programmes.

A further clinical implication of the findings of this study relates to the potential inclusion of personal therapy during the training of CBT therapists. In the UK, at least forty hours of personal therapy is mandatory for counselling psychologists in training (Rizq & Target, 2008). The rationale for this relates to the requirement of counselling psychologists to possess a high level of self-awareness in order that they may utilise their knowledge of personal and interpersonal dynamics in the therapeutic setting (Reupert, 2006). By contrast, the inclusion of personal therapy in the training programmes of CBT therapists is not routinely undertaken (Laireiter & Willutzki, 2005). However, in recent years there has been an acknowledgement that inclusion of personal therapy may act as an additional means of allowing the CBT therapist to increase self-awareness and to identify counter-transference enactments (Malikiosi-Loizos, 2013). Previous qualitative research has identified that therapists in training found the process of personal therapy to be an experience which allowed them to become more aware of the relationship that develops between practitioner and client, the issues of transference and counter-transference that are involved in this relationship and the development of empathy, patience and tolerance towards the client (Bike, Norcross & Schatz, 2009). Overall, these findings, in conjunction with the findings of this research project indicate that consideration of the inclusion of personal therapy in CBT training programmes may be beneficial to trainee CBT therapists.

4.2.2: Implications for the CBT protocol for OCD treatment

A further clinical implication of this research may be the need to consider the inclusion of other specific therapeutic techniques or procedures and strategies to the current CBT

protocol aimed at enhancing engagement and preventing drop-out. Recent research has suggested that specific cognitive techniques to address maladaptive distress tolerance beliefs held by the client may be a useful adjunct to the current CBT protocol to engage clients in exposure tasks (Clark, 2013). Examples of maladaptive distress tolerance beliefs are 'intolerance of negative emotion' e.g. *"it is unacceptable to be upset"*; "Emotional suppression" e.g. *"it is important to not let others see my emotions"*; "Emotional over control" e.g. *"I must maintain strict control over my emotions"* and "rationality" e.g. *"it is better to be rational and logical rather than emotional"* (Leahy, 2002). It has been suggested that a focus on the adaptation of such beliefs and shifting the focus of therapy to address these directly when resistance is encountered may lead to greater engagement in exposure-based exercises (Clark, 2013). It has been proposed that identifying and modifying maladaptive exposure and emotional distress beliefs along with distress tolerance skills, prior to engaging in exposure and assigning homework may be a useful addition to the CBT protocol (Clark 2013).

However, the focus on maladaptive beliefs in CBT aligns with a deficits-based approach in which the endeavour of therapeutic practice is viewed as the amelioration of problematic cognitions and behaviours, and focuses predominantly on what is insufficient, absent or 'wrong' with the client (Maddux, 2008). Such an approach is rooted in the 'medical model' and positivist paradigm which has dominated the helping professions since the 19th Century (Maddux, 2008). Within this model the practitioner is positioned as the 'expert', possessing the solutions to the clients' presenting problem. An alternative perspective, known as the strengths-based approach, has recently gained attention as a result of the increasing interest in positive psychology (Peterson & Seligman, 2004). A focus on strengths is argued to move the practitioner away from viewing the client as a problem to be solved and instead facilitates discovery of the individual's knowledge, abilities, virtues and aspirations, which are emphasised and drawn upon to aid the recovery process (Rashid, 2015). The themes outlined in the practitioners' experiences in their work with clients with OCD indicate that a primary focus on deficits was adopted, potentially contributing to difficulty in viewing the therapeutic endeavour as a collaborative effort, and potentially creating an unhelpful power dynamic within the therapeutic relationship. Therefore, a clinical implication of this research may be the incorporation of elements of a strengths-based approach in CBT for OCD. The integration of an understanding of clients' strengths within the CBT

offered to those with OCD may realign the negatively skewed narrative that is traditionally presented, and allow clients to focus on how they may use the strengths, skills, talents and abilities they already possess to overcome the challenges they are encountering (Rashid, 2015). Such an approach has been shown to be effective in terms of outcomes, with a recent investigation indicating that CBT personalized towards clients' skills resulted in better outcomes than CBT personalized towards a clients' deficits in the treatment of depression (Cheavens, Strunk, Lazarus & Goldstein, 2012). Recent research has indicated that a strengths-based approach can aid the development of a trusting therapeutic relationship and increased client motivation to engage in therapy (Scheel, Davis, & Henderson, 2012).

4.2.3: Implications for organisational policy

Time constraints placed on clinicians, particularly within an NHS context, may limit opportunities for in-vivo ERP to be undertaken as this may involve leaving the therapy room and travelling to locations or situations identified as triggering clients' intrusive thoughts. Arguably, therefore, a change in organisational policy extending the session time for those undertaking ERP work, in order that this form of work could be completed may enhance client engagement and outcome as greater treatment compliance is known to be a predictor of treatment response (Tolin, Maltby, Diefenbach, Hannan & worhunsky, 2004; Whittal, Thordarson & McLean, 2005). Therefore, the creation by service managers of a more flexible environment in which this becomes a more viable option for clinicians may be warranted, enhancing client engagement in treatment, reducing drop-out and improving clinical outcomes. In addition, given that the provision of a credible rationale and an explanation for symptoms being experienced by clients have been identified as key non-specific therapeutic factors (Frank, 1982), the provision of extra time in therapy to complete this with clients known to struggle with engagement may be particularly beneficial. A further argument for improved time management strategies is the time needed for the management of the therapist's own wellbeing in order to prevent burn-out. A key criterion within the HCPC guidelines is a psychologist's ability "*to manage the physical, psychological and emotional impact of their practice"* (HCPC, 2015, p 8.). Therefore, a practice implication of this study is the heightened awareness of the potential for emotional challenges on the part of the therapist when working with this

client group, and the need to address this within supervision in order to maintain the effectiveness of the therapy but also to ensure the wellbeing of therapists themselves, particularly when working in a high pressure and time-poor environment, such as IAPT.

4.3 Recommendations for Future Research

This research project builds on previous qualitative and quantitative research exploring clinicians' experience of delivering CBT to clients with OCD. This research adds to the literature base by providing qualitative insight into therapists' experience of delivering high-intensity therapy, which is the most common form of treatment for those presenting to services with OCD (Gellatly et al., 2017). A number of questions have emerged from the study, which warrant further investigation.

Firstly, this study identified certain attitudes and behaviours that are activated in those delivering treatment to clients with OCD. The mechanisms by which therapist counter-transference may impact on client engagement and drop-out has been speculative, and further research would be needed to validate and further elucidate these assertions. Therefore, a useful piece of research would be a quantitative enquiry regarding the impact of certain therapists' dimensions such as 'concern over mistakes' and 'high standards for others' and the impact of such dimensions on outcome measures of CBT for OCD and on client drop-out rates. Adding to this, a qualitative enquiry regarding the clients' experience of receiving high-intensity CBT for OCD, with a specific focus on the clients' experience of the way in which the treatment rationale and treatment procedure is delivered, may allow further insight into the aspects of treatment delivery affecting client engagement and drop-out. The comparison of therapist and client perspectives, in addition to outcome data, may allow for a more complete understanding of this topic area. Investigations exploring the impact of incorporating and encouraging a space for reflection on the therapist's counter-transference within their clinical supervision and the impact of this reflection on the therapeutic relationship and on client engagement within CBT for OCD, would be beneficial.

This research has highlighted some of the potential areas for further development of the CBT protocol in order to allow for better client engagement. The development of protocols including the targeting of maladaptive distress tolerance beliefs prior to

exposure work and the quantitative measurement of the impact of such a protocol on client outcomes, adherence and engagement with the treatment, may be of benefit. Once again, undertaking a qualitative enquiry into the clients' experience of the addition of any distress tolerance techniques would further illuminate this topic area. Further, the inclusion of motivational interviewing requires greater investigation. Previous research has quantitatively explored the use of motivational interviewing in combination with a standard ERP protocol (Simpson & Zuckoff, 2011). Further qualitative investigation regarding therapists' experience of delivering such a protocol in addition to qualitative investigation into clients' experiences of receiving it would be a useful addition to the literature base and clinical practice. Lastly, research regarding the effectiveness of the incorporation of a strengths-based approach into the current CBT protocol in order that those with OCD may build upon the positive qualities and strengths they already possess, may present a new frontier for research.

4.4 Critical Evaluation of the Research

4.4.1 Sensitivity to Context

The evaluative criteria for qualitative research outlined by Yardley (2000) will be used to critique the research presented in this report due to the criteria being flexible and broad enough that they are applicable to a wide range of qualitative methodologies (Yardley, 2000). A key criterion of good quality qualitative research relates to ensuring a worthy topic of interest that demonstrates sensitivity to context, meaning that the research question must be situated and contextualised within the pre-existing literature in order to identify a genuine 'gap' in the current understanding which new research would be able to fill. A comprehensive literature review was conducted prior to arriving at the research question for this study. As previously stated, no prior qualitative investigation regarding the subjective experiences of those delivering high-intensity CBT to individuals with OCD has been conducted and therefore a clear gap in the literature was identified.

Showing sensitivity to context was attended to within the data collection stage of this research through the consideration of the environment in which the research interviews took place. As professionals were being interviewed, a professional space away from their place of work was used to ensure they felt comfortable freely discussing their

experiences. Lastly, sensitivity to participants' perspectives was ensured through the creation of open-ended interview questions that would facilitate participants speaking openly about their experiences rather than being constrained by the researcher's own concerns and agenda. However, owing to my relative inexperience as a researcher the interview technique used in the initial interviews may, on reflection, have prevented the participant from fully sharing their experience in-depth due to my hesitancy with probing the participant further. Having reflected on the pilot interview with my research supervisor, I was able to develop my interview technique as the research progressed, allowing for rich and in-depth accounts of the therapists' subjective experiences to be obtained.

During the analysis of the research, sensitivity to the socio-cultural context of the participants was considered in terms of what aspects of their experience they may have chosen to share or not share. A limitation of this study is the awareness that the participants had of my status as a trainee psychologist due to the transparency that was necessary in the recruitment phase of the study. My status as a trainee may have led participants to assume a level of understanding regarding conducting CBT for OCD which may have impacted on what they felt it was necessary or not to share or elaborate on. My impact on the data collection stage will be explored in-detail in the self-reflexivity section 4.5. Steps were taken to ensure that participants felt able to share positive and negative aspects of their experience through explicitly giving opportunity for this in the interview schedule and through reminding them of complete anonymity in the research process and write-up.

4.4.2 Commitment and Rigour

Qualitative research can be evaluated on its commitment and rigour (Yardley, 2000). Commitment within qualitative research can be evidenced through the researcher's diligence in ensuring appropriate and sufficient time, effort, care and thoroughness has been applied to the research process in a manner that reflects the complexity of the phenomena being studied. Commitment was demonstrated in this case through the extensive literature review, immersion in the participants' accounts and the researcher's detailed attention to appropriate research practices. Rigour relates to the completeness of the data collection and analysis procedures (Yardley, 2000). Procedural rigour can be assessed through demonstrating that a competent and thorough data collection and

analysis process was used to arrive at the findings. Detailed rationale for the choices made regarding the data collection and data analysis strategy have been thoroughly documented. However, several limitations of this study can be identified within the data collection phase, which will now be explored. As the participants were free to express an interest in taking part in the study it is possible this may have resulted in a sampling bias such that those participating may have had held particularly negative or positive views regarding delivering CBT to those with OCD, or may have held a personal interest in the subject area. Such biases may have skewed the data collected and therefore the resulting analysis and findings. In particular, one participant in this study disclosed that they themselves had experienced OCD in the past and had undergone CBT to overcome this issue. This may have impacted on the experience of this participant, differing from the experiences of therapists who have not previously experienced OCD. In addition, the time and resources allocated in order to complete this study resulted in further limitations with regards to sampling, however a sample size of eleven falls well within the six to fifteen participants recommended for a thematic analysis completed at a professional doctorate level (Braun & Clarke, 2013).

With regards to data analysis, thematic analysis as a methodology seeks to identify themes across an entire dataset (Braun & Clarke, 2013). This was required in this case due to the commitment to produce findings that were applicable to a wide audience in order to maximise its impact and importance to practicing clinicians. However, it is acknowledged that in adopting such an analysis some of the richness of the individual accounts may have been lost (Braun & Clarke, 2006). Interpretative Phenomenological Analysis (IPA) in contrast adopts an idiographic approach (Smith et al., 2009). The term idiographic has its semantic origins in the Greek word *idos* meaning the individual (Ponterotto, 2005). As such, idiographic research attempts to examine how particular people have experienced particular events (Smith, 2015) and views the individual as a unique entity (Ponterotto, 2005). This contrasts with nomothetic research, which seeks to understand phenomena at a group level in order to identify universal laws and patterns (Ponterotto, 2005). IPA retains a commitment to idiography within the data analysis process by beginning with a detailed examination of the individual cases before tentatively offering claims at a more general level (Smith et al., 2009). As such, adopting an IPA approach may have allowed for a deeper insight into the individual experiences of delivering CBT for OCD. However, IPA is less consistent with the

critical realist epistemological position adopted in this study whereas thematic analysis allows such an epistemological position to be utilised.

Independent verification of the coding and data analysis process by individuals not involved in the research project did not take place within this research project. The researcher's own subjectivity was acknowledged to have impacted on the analysis process and therefore gaining multiple independent coders would not have been appropriate in this instance. Anonymised coded data extracts were shared, and candidate themes were discussed with the research supervisor, permitting a level of quality assurance.

An important aspect of rigour is the credibility of the findings. Credibility can be enhanced through a process of member checking. A process of member checking allows the researcher to return the findings to the participants in order to ensure that the interpretations resonate with the participants (Merriam, 2002). Member checking did not take place in this study, which may have strengthened the validity of the findings.

4.4.3 Coherence and Transparency

Qualitative research can also be evaluated in terms of its transparency and coherence (Yardley, 2000). Transparency relates to the auditability of the research such that sufficiently detailed explanations regarding all aspects of the data collection and analysis procedures are outlined with the reasoning for utilising such methods being explicitly expressed (Ryan, Coughlan & Cronin, 2007). Within this research detailed descriptions of the choice of methodology, sampling procedures and data collection procedures have been clearly documented and a full interview schedule has been provided in Appendix 6 of this report. A detailed description of the data analysis process has also been documented and examples of coding and theme development stages have been provided in the appendices of this report in order to enable the reader to audit the actions of the researcher (Koch, 2006). Transparency was also attended to in this research through the supply of raw data extracts such that the reader can observe the link between the data set and the analysis (Yardley, 2000).

4.5 Self-Reflexivity

One of the fundamental practices within qualitative research that can enhance the transparency of the research is that of self-reflexivity (Yardley, 2000). Self-reflexivity is a process by which the researcher examines and questions their presuppositions, biases and motivations to engage in a chosen research project (Tracy, 2010). Qualitative research positions the researcher as central in the research process, acknowledging that any understanding regarding a particular phenomenon is a product of the researcher's interpretation of the participant's account (Willig, 2013). A reflexive attitude is therefore called for, and engaging in such a practice is a marker of quality in qualitative research (Yardley, 2000). I have actively engaged with this process of self-reflection throughout all stages of the research project by keeping a reflexive research diary, extracts of which are shown in Appendix 11.1 and Appendix 11.2. In order to engage with the process of self-reflexivity I attempted to clarify my personal motivations for undertaking this particular research project in addition to my values and my positioning as a researcher based on factors such as my gender, race and socioeconomic status. The following section will seek to highlight the potential impact that I as the researcher had upon the research process.

My personal motivation to engage in this study stems from having delivered CBT to those with OCD and having witnessed the profound impact this form of treatment can have on improving the quality of clients' lives and alleviating their symptoms. Whilst my prior clinical experience in this area greatly enhanced my interest in the subject area, my assumptions regarding the usefulness of CBT as a therapeutic modality as a whole, in addition to my perceptions of the impact of specific CBT therapeutic interventions on client engagement may have biased what I attended to during the interview stage. For example, within my own clinical practice I have experienced issues with client engagement in the ERP element of the treatment. This personal experience may have impacted on the follow-up questions I asked and my response, whether verbal or non-verbal, to participant's answers. This in turn may have resulted in certain areas being over- or under-explored during the interview process, which may have impacted on the quality and breadth of the data. As a result of this, it is possible that I will have attended more to the challenges faced by clinicians, in particular those that fit with my own experience. While the interview schedule attempted to gain the participant's perspective on aspects of treatment that both facilitated and diminished client engagement, on

reflection it may have been useful to include a broader range of explicitly positively framed questions in order to fully explore this aspect of their experience in greater depth. I additionally reflected on how my status as a trainee psychologist in addition to a researcher may have impacted on the participant, for example participants may have been concerned with presenting their practice in a favourable light knowing that I also have experience of working clinically, this may have affected what they chose to share or not to share regarding their experiences of delivering CBT which may in turn may have impacted on the findings.

Further to this owing perhaps to the fact that I am a clinician interviewing other clinicians, I noticed that during the interviewing stage I frequently felt hesitant when enquiring about the experience of the participant further. In some instances, participants appeared to verbally deny any impact of the therapeutic work on themselves; however, their body language suggested this may not be the case. I was faced with an ethical tension in this instance as I sensed that there was more to explore here, but I wanted to respect the privacy of the participant and was aware that by attempting to understand their experience in more detail I may cause distress or open up an area of exploration they did not feel comfortable with. However, in taking their words at face value, important knowledge may have been lost and if the wider societal purpose of conducting the interview is to uncover such knowledge in order to improve practice I questioned my obligation to attempt to move beyond the participants' defences. In hindsight this hesitancy may have impacted on the depth of data that was collected which may have in turn affected the eventual findings of the study.

During the data analysis phase I was aware of how my prior clinical experience may have affected the way in which I interpreted and made sense of the data. I endeavored to become aware of my biases through my reflective journal and additionally through research supervision, which enabled me to focus my attention on those assumptions that were outside of my awareness and to openly question my biases and presuppositions. Further to this in the data analysis phase I reflected on issues of power, because during this phase of the research, it was myself as the researcher who had access to pertinent theories that I was able to draw upon in order to describe and make interpretations about the participant's experience. Therefore, I was aware I must be sensitive to researcher dominance and miscommunication (Cohn & Lyons, 2003). One way this this could be

adequately addressed in the future would be through incorporating 'member checking' into the research design in which the findings would be presented to participants and asked to offer feedback as a means realign the power balance.

4.7 Conclusion

This thesis presents a thematic analysis of the subjective experiences of high-intensity therapists' experiences of delivering CBT to clients with OCD. The findings have demonstrated the impact of therapist factors, client factors and contextual factors on clinician's experience of delivering individual CBT for OCD.

The perceived complexity of OCD, the reported difficulties with clients completing homework assignments, the additional complexities presented by co-morbidity, the time-pressure when working within the NHS, and the professed limits of the CBT model, all created the conditions in therapy that resulted in triggering the adoption of a more didactic stance amongst participants. The adoption of such a stance may be a factor implicated in client non-adherence and dropout from CBT treatment for OCD through the impact that this may have on the therapeutic relationship. Therefore, further time in clinical supervision and in training programmes should be given to acknowledge the potential impact of the therapist's subjective and objective counter-transference within the context of a cognitive framework, in order to allow for the conditions in which the therapeutic relationship may be strengthened and therapeutic impasses resolved. Advocating for greater attention to be brought to the impact of the therapeutic relationship on the process of CBT for OCD is in line with counselling psychology values which are *"grounded in the primacy of the counselling or psychotherapeutic relationship"* (BPS, 2005, p1).

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Appendix 1: Literature Search Terms

Appendix 1.1: Literature search regarding mental health practitioner's experiences of delivering CBT

Search Terms:

S1 Mental health practitioner experience

S2 Psychologist experience

S3 Clinician experience

S4 Therapist experience

S5 S1 or S2 or S3 or S4

S6 CBT

S7 Cognitive therapy

S8 Cognitive behavioural therapy

S9 ERP

S10 Exposure and Response Prevention

S11 S6 or S7 or S8 or S9 or S10

S12 S5 AND S11

A total of three hundred and nineteen articles were identified using the above search terms. The abstracts of these articles were reviewed for relevance to mental health practitioner's experience of delivering CBT. Where possible articles were disregarded on the basis of title. References of relevant articles were hand searched to identify further literature. Grey literature sources such as conference presentations and unpublished manuscripts were search to identify pertinent literature.

Appendix 1.2: Literature Search regarding mental health practitioner's experiences of delivering CBT to those with OCD

S1 Obsessive-compulsive disorder
S2 OCD
S3 S1 or S2
S4 Mental Health Practitioners experience
S5 Psychologists experience
S6 Clinician experience
S7 Therapist experience
S8 S4 or S5 or S6 or S7
S9 Cognitive therapy
S10 CBT
S11 Cognitive-behavioural therapy
S12 ERP
S13 Exposure and Response Prevention
S14 S9 or S10 or S11 or S12 or S13
S15 S3 AND S8 AND S14

These search terms were used in the following databases: PsychINFO; PsychARTICLES and Academic Search Complete. Limits applied to the searches were: Language: English Subject: Human

A total of twenty articles were identified using the above search terms. The abstracts of these articles were reviewed for relevance to mental health practitioner's experience of delivering CBT to those with OCD. Where possible articles were disregarded on the basis of title. References of relevant articles were hand searched to identify further literature. Grey literature sources such as conference presentations and unpublished manuscripts were search to identify pertinent literature.

Appendix 1.3: Literature Search regarding client experience of CBT for OCD

S1 Patient Experience

S2 Client Experience

S3 User Experience

S4 S1 or S2 or S3

S5 CBT

S6 Cognitive Therapy

S7 Cognitive Behavioural Therapy

S8 ERP

S9 Exposure and Response Prevention

S10 S5 or S6 or S7 or S8 or S9

S11 OCD

S12 Obsessive Compulsive Disorder

S13 S11 or S12

S14 S4 AND S10 AND S13

These search terms were used in the following databases: PsychINFO; PsychARTICLES and Academic Search Complete. Limits applied to the searches were: Language: English Subject: Human

A total of thirty one articles were identified using the above search terms. The abstracts of these articles were reviewed for relevance to client experience of receiving CBT for OCD. Where possible articles were disregarded on the basis of title. References of relevant articles were hand searched to identify further literature. Grey literature sources such as conference presentations and unpublished manuscripts were search to identify pertinent literature.

Appendix 1.4: Literature search regarding client satisfaction and acceptability of CBT for OCD

S1 Patient Acceptability
S2 Patient Satisfaction
S3 S1 OR S2
S4 CBT
S5 Cognitive Therapy
S6 ERP
S7 S4 OR S5 OR S6
S8 Obsessive compulsive disorder
S9 OCD
S10 S8 OR S9
S11 S3 AND S7 AND S10

These search terms were used in the following databases: PsychINFO; PsychARTICLES and Academic Search Complete. Limits applied to the searches were: Language: English Subject: Human

A total of thirteen articles were identified using the above search terms. The abstracts of these articles were reviewed for relevance to client experience of receiving CBT for OCD. Where possible articles were disregarded on the basis of title. References of relevant articles were hand searched to identify further literature. Grey literature sources such as conference presentations and unpublished manuscripts were search to identify pertinent literature.

Appendix 2.1: Ethics Approval

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

REVIEWER: Laura Mcgrath

SUPERVISOR: **Melanie Spragg**

STUDENT: Natasha Baird

Course: Professional Doctorate in Counselling Psychology

Title of proposed study: TBC

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY
(Please indicate the decision according to one of the 3 options above)

Approved, with minor amendments

Minor amendments required *(for reviewer)*:

More clarification on how consent/coercion will be managed when recruiting through private psychologists. Also, may want to widen the locations for interviews as all participants may not feel comfortable in a university location.

Major amendments required *(for reviewer):*

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data. Student's name *(Typed name to act as signature):* Natasha Baird Student number: U1618106 Date: 06/07/2018 *(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)*

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

Has an adequate risk assessment been offered in the application form?

YES / NO

Please request resubmission with an adequate risk assessment

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐ HIGH

Please do not approve a high risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.

	MEDIUM (Please approve but with appropriate recommendations)
X	**LOW**

Reviewer comments in relation to researcher risk (if any).

Reviewer *(Typed name to act as signature)*: *Laura McGrath*

Date: 16.5.2018

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

Appendix 2.2: Ethics Amendments Approval

UNIVERSITY OF EAST LONDON
School of Psychology

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology.

Note that approval must be given for significant change to research procedure that impacts on ethical protocol. If you are not sure about whether your proposed amendment warrants approval consult your supervisor or contact Dr Mary Spiller (Chair of the School Research Ethics Committee).

HOW TO COMPLETE & SUBMIT THE REQUEST

1. Complete the request form electronically and accurately.
2. Type your name in the 'student's signature' section (page 2).
3. When submitting this request form, ensure that all necessary documents are attached (see below).
4. Using your UEL email address, email the completed request form along with associated documents to: Dr Mark Finn at m.finn@uel.ac.uk
5. Your request form will be returned to you via your UEL email address with reviewer's response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.
6. Recruitment and data collection are **not** to commence until your proposed amendment has been approved.

REQUIRED DOCUMENTS

1. A copy of your previously approved ethics application with proposed amendments(s) added as tracked changes.
2. Copies of updated documents that may relate to your proposed amendment(s). For example an updated recruitment notice, updated participant information letter, updated consent form etc.
3. A copy of the approval of your initial ethics application.

Name of applicant: Natasha Elizabeth Vivian Baird

Programme of study: Professional Doctorate in Counselling Psychology

Title of research: **A qualitative study of mental health practitioner's experience of delivering individual high-intensity cognitive behavioural therapy including exposure and response prevention for obsessive compulsive disorder. A Thematic Analysis**

Name of supervisor: Dr. Melanie Spragg

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	Rationale
Change to recruiting and interviewing mental health practitioners who have delivered CBT for OCD instead of interviewing clients.	Attempts over several months to recruit and interview clients who have received CBT for OCD have not resulted in the required participants.
Change of methodology from IPA to thematic analysis.	Thematic analysis is a more flexible method that can be used within different epistemological positions as opposed to IPA, which is wedding to a pre-existing theoretical framework. Thematic analysis was deemed a more appropriate methodology than IPA given the new research question.

Please tick	YES	NO
Is your supervisor aware of your proposed amendment(s) and agree to them?	✓	

Student's signature (please type your name): Natasha Baird
Date: 12/09/2018

TO BE COMPLETED BY REVIEWER		
Amendment(s) approved	YES	
Comments		

Reviewer: Tim Lomas

Date: 27.9.18

Appendix 2.3: Title Change Approval

University of East London

REQUEST FOR TITLE CHANGE TO AN ETHICS APPLICATION

FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

Please complete this form if you are requesting approval for proposed title change to an ethics application that has been approved by the School of Psychology.

By applying for a change of title request you confirm that in doing so the process by which you have collected your data/conducted your research has not changed or deviated from your original ethics approval. If either of these have changed then you are required to complete an Ethics Amendments Form.

HOW TO COMPLETE & SUBMIT THE REQUEST

7. Complete the request form electronically and accurately.
8. Type your name in the 'student's signature' section (page 2).
9. Using your UEL email address, email the completed request form along with associated documents to: Psychology.Ethics@uel.ac.uk
10. Your request form will be returned to you via your UEL email address with reviewer's response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.

REQUIRED DOCUMENTS

4. A copy of the approval of your initial ethics application.

Name of applicant: Natasha Elizabeth Vivian Baird
Programme of study: Professional Doctorate in Counselling Psychology
Name of supervisor: Dr. Zetta Kougiali

Briefly outline the nature of your proposed title change in the boxes below

Proposed amendment	Rationale
Old Title: A qualitative study of mental health practitioner's experiences of delivering individual high-intensity cognitive behavioural therapy including exposure and response prevention for obsessive compulsive disorder: A Thematic Analysis**.**	The new proposed title better represents the purpose and nature of the research study.
New Title: *"Desperately Banging on the Door*": High-Intensity Therapist's Experience of Delivering Cognitive Behavioural Therapy to Individuals with Obsessive Compulsive Disorder: A Thematic Analysis	

Please tick	YES	NO
Is your supervisor aware of your proposed amendment(s) and agree to them?	X	
Does your change of title impact the process of how you collected your data/conducted your research?		X

Student's signature (please type your name): Natasha Baird

Date: 06/12/2019

TO BE COMPLETED BY REVIEWER		
Title changes approved	APPROVED	
Comments:		

Reviewer: Glen Rooney
Date: 09/12/2019

Appendix 3: Participant Information Sheet

PARTICIPANT INVITATION LETTER

You are being invited to participate in a research study. Before you agree it is important that you understand what your participation would involve. Please take time to read the following information carefully.

Researcher:
I am a postgraduate student within the School of Psychology at the University of East London and I am studying for a Professional Doctorate in Counselling Psychology. As part of my studies I am conducting the research you are being invited to participate in. This research is being overseen by Dr. Melanie Spragg (Chartered Counselling Psychologist and senior lecturer at the University of East London).

Purpose of the research:

High-intensity psychological interventions for Obsessive Compulsive Disorder (OCD) are comprised of ten hours or more face-to-face sessions providing Cognitive Behavioural Therapy (CBT) including Exposure and Response Preventions (ERP).

Research regarding CBT for OCD is dominated by quantitative methods of enquiry demonstrating the clinical effectiveness of this form of treatment. However, dropout and non-engagement rates within these randomized control trials are high.

There is limited understanding of practitioners experience of delivering CBT for OCD. Therefore, this research study aims to understand mental health practitioner's personal experience of delivering individual high-intensity CBT for OCD. Such an investigation will offer insights into practitioner's perspectives on client engagement and the aspects of treatment that may facilitate adherence to CBT for OCD. Such insights may allow for improvements to be made to clinical practice in order to increase patient acceptability of CBT for OCD, potentially reducing dropout rates.

This research project has been approved by the School of Psychology Research Ethics Committee. This means that my research follows the standard of research ethics set by the British Psychological Society.

Why have you been asked to participate?
I am looking to recruit participants who are willing to share their thoughts on their experience of delivering individual high-intensity CBT sessions for clients with OCD.

I am looking to involve individuals who are qualified counselling psychologists, clinical psychologists or CBT therapists registered with the BABCP. All participants must have

delivered high-intensity CBT (including ERP) to clients diagnosed with OCD.

What will your participation involve?

If you agree to participate you will be asked to sign a consent form. You will then be invited to attend one informal interview with myself at a time that is convenient to you. This interview should last between 1-1.5 hours. It is proposed that these interviews will take place at the University of East London, Stratford however other central London locations can be arranged. Alternatively the interviews may be conducted via Skype. The interview will be audio recorded with your permission. Any information gathered in the interview will be made anonymous when used within the research study in order that you cannot be identified. The data collected will be used for the purposes of this research study only.

You will be invited to feedback on the findings of the study if you wish to do so and this feedback may be incorporated into the research project. You will not be financially reimbursed for participating in this research but your participation would be very valuable in helping to develop knowledge and understanding of the research topic and may help improve CBT treatment for people experiencing OCD in the future.

Your taking part will be safe and confidential

Your privacy and safety will be respected at all times. All information gathered as part of the interview will be kept confidential however in the instance that you disclose risk of harm to yourself or others I may need to inform the relevant services in order that they can support you.

What will happen to the information that you provide?

The tape recording of the interview along with any personal data will be kept confidential in line with the Data Protection Act (2018). This information will be stored securely on password-protected university computers accessible only by the primary researcher.

The data you provide in the interview will be anonymised within the write-up of the study, through the use of pseudonyms (false names), in order that you will not be able to be identified. The findings of the study may be published in academic journals or presented at relevant conferences in order to disseminate the findings of this research. You will not be identified in any such publications.

All audio-recorded data and personal data will be destroyed on completion of the study. In order to allow for the development of the research for possible publication, anonymised interview transcripts and data analysis will be stored for five years from the date of completion of the study and subsequently destroyed.

On request, the researcher can provide you with a written summary of the findings if you wish.

What if you want to withdraw?

You are free to withdraw from the research study at any time without explanation, disadvantage or consequence. However, if you withdraw beyond the point of data analysis I would reserve the right to use material that you provide in the write-up of the study.

Contact Details

If you would like to take part in this research project please contact me using the details below:

Name: Natasha Elizabeth Vivian Baird
E-mail: u1618106@uel.ac.uk

If you have any questions or concerns about how the research has been conducted please contact the research supervisor Dr. Melanie Spragg. School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: m.spragg@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Mark Finn, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Email: m.finn@uel.ac.uk)

Appendix 4: Research Advertisement

Are you a CBT therapist, counselling psychologist or clinical psychologist?

Would you like to talk confidentially about your experience of delivering cognitive behavioural therapy for obsessive compulsive disorder?

Sharing your experiences of delivering CBT may allow for improvements to be made to the treatment offered to clients in the future.

Please contact Natasha Baird
(Counselling Psychologist in Training, UEL)
at u1618106@uel.ac.uk
if you would like to be involved in this research project

Appendix 5: Participant Consent Form

UNIVERSITY OF EAST LONDON

Consent to participate in a research study

A qualitative study of mental health practitioner's experience of delivering individual high-intensity cognitive behavioural therapy (CBT) including exposure and response prevention (ERP) for obsessive compulsive disorder (OCD). A Thematic Analysis

I have the read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher and research supervisor involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study, which has been fully explained to me. I give consent for the research interview to be audio recorded. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw, the researcher reserves the right to use my anonymous data after analysis of the data has begun.

Participant's Name (BLOCK CAPITALS)

…….

Participant's Signature

……..

Researcher's Name (BLOCK CAPITALS)

……..

Researcher's Signature

……

Date: ……..…….

Researchers Contact E-mail: u1618106@uel.ac.uk ; Research Supervisors E-mail: m.spragg@uel.ac.uk

Appendix 6: Interview Schedule

Opening

- Welcome the participant, thank them for taking part.
- Reiterate the purpose of the study and remind the participant they may terminate the interview at any time they wish
- Review confidentiality/consent and the participation letter.
- Provide an opportunity to ask me any questions.

Background:

1. Please could you tell me about yourself such as your age, current job title and number of years of clinical experience using CBT?

Experience:

1. Could you tell me a bit about your general experience of delivering individual CBT treatment for clients with OCD?

   -How did the experience of working with people with OCD impact on you?

   -What was that like for you?
2. In your experience, what challenges or issues have you faced with delivering CBT for OCD?

   -What was that like for you?
3. From your experience what aspects of CBT do you perceive to influence or impact upon clients engagement and adherence to treatment?

   -What was that like for you when clients struggled to engage?

   -Can you give me an example?
4. What has been your experience of delivering exposure and response prevention tasks to clients?
5. From your experience, what aspects of the treatment facilitate the client's engagement with ERP?
6. From you experience, what aspects of the treatment diminish client's engagement with ERP?
7. What has been your experience of creating a therapeutic relationship with clients with OCD when using CBT?
8. In your experience, what particular aspects of the therapeutic relationship impact on client engagement with CBT?
9. What has been your experience of involving family members in CBT for OCD?
10. What has been your experience of ending therapy CBT treatment with clients experiencing OCD?

11. On reflection, is there anything about the CBT treatment that you have delivered to clients in the past that you would wish to alter or change in the future?
12. Is there anything else about your experience of delivering CBT to clients with OCD that you would like to discuss?

Closing

- Is there anything else you might like to add?
- Are you happy for us to end the interview here?
- Thank the participant and offer the chance to ask any questions
- Debrief – discuss the issues on the debriefing form.

Possible Probes:

1. Can you tell me what you mean by that?
2. Could you expand on that experience in more detail?
3. Could you give me an example?

Appendix 7: Participant De-Brief Sheet

UNIVERSITY OF EAST LONDON

PARTICIPANT DEBRIEF SHEET

A qualitative study of mental health practitioner's experience of delivering individual high-intensity cognitive behavioural therapy (CBT) including exposure and response prevention (ERP) for obsessive compulsive disorder (OCD). A Thematic Analysis.

Thank you for participating in this research study.

The information you provided in your interview will be kept confidential and will be anonymised within the write up of this research and in any subsequent publications. All data generated by this interview will used for the purposes of this research project only.

If you were upset or distressed in any way by the interview process please contact your clinical supervisor, who will be able to offer you some support.

If you have any questions regarding your participation in this study or if you would like to request a written summary of the findings, please contact the primary researcher or the research supervisor using the contact information below:

Primary Researcher: Natasha Elizabeth Vivian Baird. E-mail: u1618106@uel.ac.uk

Research Supervisor: Dr. Melanie Spragg. E-mail: m.spragg@uel.ac.uk

I would once again like to take this opportunity to thank you for participating in this research project.

Appendix 8: Transcription conventions Key

P:	Indicates participant
I:	Indicates interviewer
( )	Indicates pause in speech
[unclear]	Indicates unclear speech
[ ]	Indicates when a comment has been added by the author
< >	Indicates interruption
/	Indicates overlapping speech
-	Indicates unfinished word
X	Identifying information removed

Adapted from Parker (2005)

Parker, I. (2005). Qualitative Psychology: Introducing Radical Research. Berkshire, England: Open University Press.

Appendix 9: Examples of Transcript with Handwritten Codes

Interview Pseudonym: Amelia

gather/<I:Mmm>/umm but generally from what I can recall assessments tend to you know be quite detailed because you know the amount of information that you have to collect/<I:Mmm>/is very important going forward with the treatment and often you end up with umm different sort of subtypes of OCD because obviously the disorder is actually spread across different areas/<I:Mmm>/which makes then treatment even more difficult umm yeah.

I: Ok so you mentioned something about often feeling overwhelmed or experiencing that with the amount of information/<P<right yeah>/can you tell me a bit more about that and also how you manage that when you are using CBT with clients with OCD?

P: Mmm so so I mean for example if I assess someone and the information is a lot because as I said the client is experiencing OCD across different areas then I would need to umm do something that normally I wouldn't have the time to do with other clients and that is to sit and just get some time to reflect and organise my data/<I:Mmm>/ which is not something that you often have the time to do in a primary care setting where you have to see people back to back where you don't have that time to reflect but I found that in the past with the OCD that was quite essential for me to do/<I:Mmm>/so that in my mind at least the information was organised in such a manner that if I then had to come up with different hierarchy's so that we would know where to start from that information was very clear in my mind/<I:Mmm>/and also to make sure that I would err simplify things as much as possible so errr just perhaps not utilising all the data<I:Mmm>but just trying to get you know the most important to do that sort of organisation of that data and then use that for treatment I am not quite sure if /<I:mmm>/I have explained myself so sometimes you don't have to go through every single detail because that's when the therapy becomes overwhelming but if you have a sense of you know the theme across different areas then you can you know umm collect data according to that particular area<I:Mmm>umm and then you know organise a hierarchy obviously collaboratively with the client and then do your piece of work but as a therapist I would need to have done that sort of work umm prior to presenting this idea to the client so you know where do we start from how do we organise ourselves around all that we have learnt and we have you know gathered.

Feeling overwhelmed with the volume of data.

Drowning in the complexity

Heterogeneity of OCD symptoms is a challenge.

Limited time to reflect

Working within tight timeframes

The desire to plan and organise.

The need to categorise

Therapist leading the 'organisation' rather than doing this collaboratively with the client.

Reduced collaboration

Structure and control.

Emphasis on structure and control in an attempt to prevent feeling lost.

Therapist as expert.

4

I: Mmm so it sounds like there is something there about the reflection and having your own space to reflect<P:yeah> on the information<P:yeah>in order to try and simplify and organise as you said ok and so what has been your experience once you have done that?

P: Ummm so I think well it depends who I am treating obviously so the people who would be struggling from a psychological point of view to take on board/<I:Mmm>/ things because of I don't know language barriers and things like that I would actually be leading you know the the work and actually tell the client this is what we are going to do umm having already made decisions as to what the hierarchy is going to be<I:Mmm>like and how we are going to tackle it just to avoid the client getting confused but obviously that knowledge would come from me knowing who I am dealing with and knowing their limitations<I:Mmm>so I am thinking about this because I have had a lot of clients who's first language wasn't English and err were not particularly psychologically minded so that was very essential to do just to be very practical and very directive whereas with clients who are more psychologically minded obviously the approach would need to be a bit more collaborative so giving them the choice as to what to put on the hierarchy umm based on a mutual understanding of what was the problem/<I:Mmm>/so that would take perhaps a number of sessions/<I:Mmm Mmm>/ umm but yeah generally speaking I have never found a problem.

I: Ok so it sounds like there was something there about really knowing the client and tailoring kind of your approach/<P:yeah depending on>/in terms of how the information is being presented

P: Yeah although at times to be honest with you umm I felt err not very skilled at kind of pulling things together precisely because of what I said before there was far too much and the feeling was where do I start from yeah you know it is too complex<I:Mmm>there is too many things going on every turn you take there is something else coming up and that was often especially at the beginning of my training the feeling that I got<I:Mmm>I was feeling feeling a bit lost err you know with all this data and the different things that the client was presenting<I:Mmm>with also because you know OCD goes with you know attention to detail and you know having to do things in a certain way so the descriptions of what the patient

Becoming directive when the client struggles to understand the model

Making decisions on the clients behalf.

Therapist allowing (a bit more) collaboration if the client is engaging.

Therapist having high expectations of herself and feeling doubtful of her practice

overly didactic + directive.

→ Reduced collaboration

↘ Therapist as expert.

Forcing the understanding

→ Self-doubt.

→ Drowning in the complexity

↘ Drowning in the complexity.

Appendix 10: Description of Analytic Procedure

Appendix 10.1: List of Identified Codes

Code
Fighting Fires
OCD symptoms difficult to conceptualise
OCD as powerful and ingrained
Drowning in the complexity
Led down a path
Getting sucked into the 'OCD world'
Can't find a way out
Going in blind
More experience required
We need a map
Therapist as expert
The need to categorize
Needing certainty through measures
Working within tight timeframes
Environmental constraints on the ERP
Model as restrictive
Too far from what I know
Lost in translation
Not just OCD
Not 'pure' CBT
Needing a relational approach
More focus on emotional regulation
Adopting an integrative stance
Transcending the model
Use of Humour
Keep it personal
OCD diagnosis masking trauma
Becoming overly didactic and directive
Emphasising the deficit
It's not my responsibility
Feeling of failure
Self-doubt

The desire to “push”
Forcing the understanding
Bubbling resentment
Avoiding the client
‘Fear’ of OCD
Overly didactic and directive
Treatment as unfinished
The struggle to disclose
Shame as a barrier
Resistance to behavioural work
Working against the addiction
I need to be there with them
Demographic barriers
Am I being mean?
Complication of family and friends
False Choice
Low Readiness to change
High Expectations
Conflicted therapist
Tug of war
Textbook examples not sufficient
Secondary gain
Needing certainty through measures
Structure and Control

Appendix 10.2: Example of Coded Data Extracts

Going in blind	"there is no OCD patient that has only got OCD, you know there are life problems and there are other things and it is the same for anyone so the case studies that you read about you know they just don't seem like the reality of what we are seeing/<I:Mmm>/" (Andy: 236) "I didn't feel after the end of my training that I had enough training to have treated OCD on my own as a fully qualified" (Mark: 712). "I have done these very textbook kind of metaphors and textbook things around the rationale and it's not really I have not really fully understood it but I have just given it a go" (Ava: 1517) "I didn't really come out of the lecture feeling 100%, not that you would feel 100% confident, but feeling overly confident/<I:Mmm>/cos the lecture I found to be quite umm there weren't a lot of examples it was all quite theoretical and I found it quite difficult" (Rachel: 29). "when I was doing my training like we had very textbook ways of kind of working with things like thought action fusion/<I:Mmm>/and you know the metaphors and the rationale and it was all this very it was quite text book basically and you know like working with thought action fusion or magical thinking where you kind of say you go away and say wish something really good happens to me and then go away and wish something terrible happens to me and I have done it before with clients and it has not felt right and I have done it because I have felt like I should" (Ava: 1480). "I have learnt since being qualified about umm spending more time on the socialisation/<I:Mmm Mmm>/than I usually would than is taught to you in the lectures I think" (Mark: 77).
Working within tight timeframes	"you have just got to the point where you have completed your assessment and formulation and you are trying to get the client on board with umm the formulation and why it might be helpful to start umm challenging the OCD and reducing some of the compulsions and then the sessions are over" (Ella: 89). "limits to the number of sessions for example and what the therapist feeling under pressure for what has got to be achieved by a certain point/<I:Mmm>/umm I think there are things like in the NHS for example there is a limited number of sessions but not only that sessions are typically hourly sessions or fifty minutes/<I:Mmm>/and you know the reality is that means you kinda thinking about your agenda you need to think about what am I going to fit into that time" (Andy: 452)

	"so obviously coming in a spending a lot of time socialising is it feels a bit wasteful to them so dealing with dissatisfaction from patients so them feeling like we are not doing the right work or it is not quick enough or it is not fast enough so that is definitely one thing" (Mark: 139). "I think for my own pressure like I have to have set some good homework otherwise we have just wasted like a whole week" (Rachel: 443). "I find the first few sessions are really key and I think actually in the training that we had they suggested up to session five or six on just understanding and psychoed but obviously in IAPT you don't really get that luxury/<I:Mmm>/and so you really want to be doing something quite soon" (Rachel: 173). "at the same time knowing that he will need a lot longer<I:Mmm>than we can offer in terms of number of sessions so he would need a lot of stabilisation type work before we can actually go straight for treatment" (Sarah:199). "I think because we have such short term interventions it is also I suppose being upfront and explaining and being as transparent as possible to begin with" (Sarah: 564). "sometimes working in IAPT because we only offer initially up to twelve sessions umm you know a sort of extended assessment can be difficult <I:Mmm> umm because you need to sort of get on with the treatment as soon as you can" (Charlotte: 76). "mindful of the amount of sessions that we can offer to people within the service and the limitations that we have umm in our service<I:Mmm>at step 3" (Charlotte: 295) "timing is sort of the essence when you can only offer so many sessions umm so yeah maybe just thinking about the treatment plan a umm little bit more and being a bit more organised with that" (Charlotte: 475). "it's going to be hard I am going to make it really hard because we have only got twelve sessions" (Ava: 1233). "more able to push things along at a much more steady pace not kind of waste therapy time umm and ahhing over situations and actually just being productive with the therapy time" (Mark: 586). "I never think about that [participant laughing]. No I don't think about that. I think we are seeing clients back to back and we are so busy we

	don't really have time to think<I:Mmm>I don't know if people have time to do research or maybe if they always do treatment for OCD then they have time to think but like today I am training and later on this you don't really have time" (Mia: 518). "Sometimes it can be quite stressful<I:Mmm yeah> sometimes I have to be honest I can feel sick physically yeah<I: you feel physically sick with not having that time> yeah you are constantly back to back<I:Mmm Mmm> so you feel sick sometimes<I:Mmm Mmm>feel sick just feel drained<I:Mmm>physically and not really having anything wrong you just feeling you don't want to talk you just feel sick feel weak" (Mia: 529).

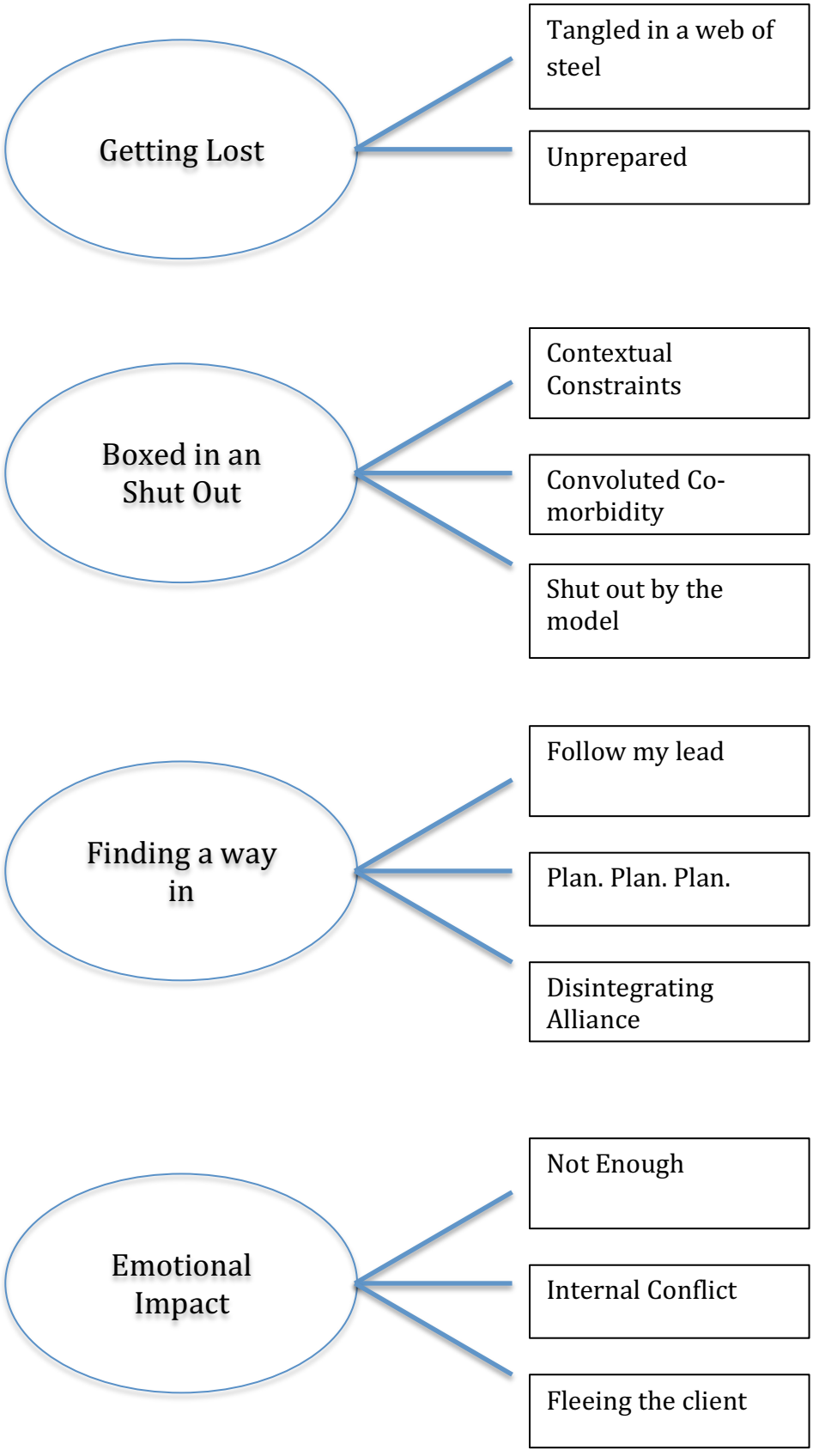
Appendix 10.3: Table of Potential Themes

Potential Themes	Grouped Codes
Tangled in a web of steel	-Fighting fires -OCD symptoms difficult to detect and conceptualise -Drowning in the complexity -Led down a path -Can't find a way out -OCD as all powerful and ingrained -Getting sucked into the OCD -Too far from what I know -Lost in translation -'Fear' of OCD
Unprepared	-Going in blind -More experience is required -Textbook examples not sufficient
Lost in convoluted co-morbidity	-Not just OCD -OCD diagnosis masking trauma
Contextual Constraints	-Working within tight timeframes -Environmental constraints on ERP -Complication of family/friends -I need to be there with them
Shut out by the client	-Working against an addiction -The struggle to disclose -Resistance to behavioural work -Secondary gain - Low readiness to change -Shame as a barrier -Demographic barriers
Limits of the model	-Not 'pure' CBT -Needing a relational approach -More focus on emotional regulation -Adopting an integrative stance -Transcending the model -Keep it personal -Use of humour

	-Emphasising the deficit -Model as restrictive
Follow my lead	-Overly didactic and directive -Therapist as expert -The desire to "push" -Forcing the understanding -Reduced collaboration
Plan, Plan, Plan	-We need a map -The need to categorize -Needing certainty through measures -Structure and control
Internal Conflict	-Am I being mean? -False choice -Conflicted Therapist
Not Enough	-Feeling of failure -Self-doubt -Treatment as unfinished -High Expectations
Fleeing the client	- Avoiding the client
Disintegrating Alliance	-Bubbling resentment -It's not my responsibility -Tug of war

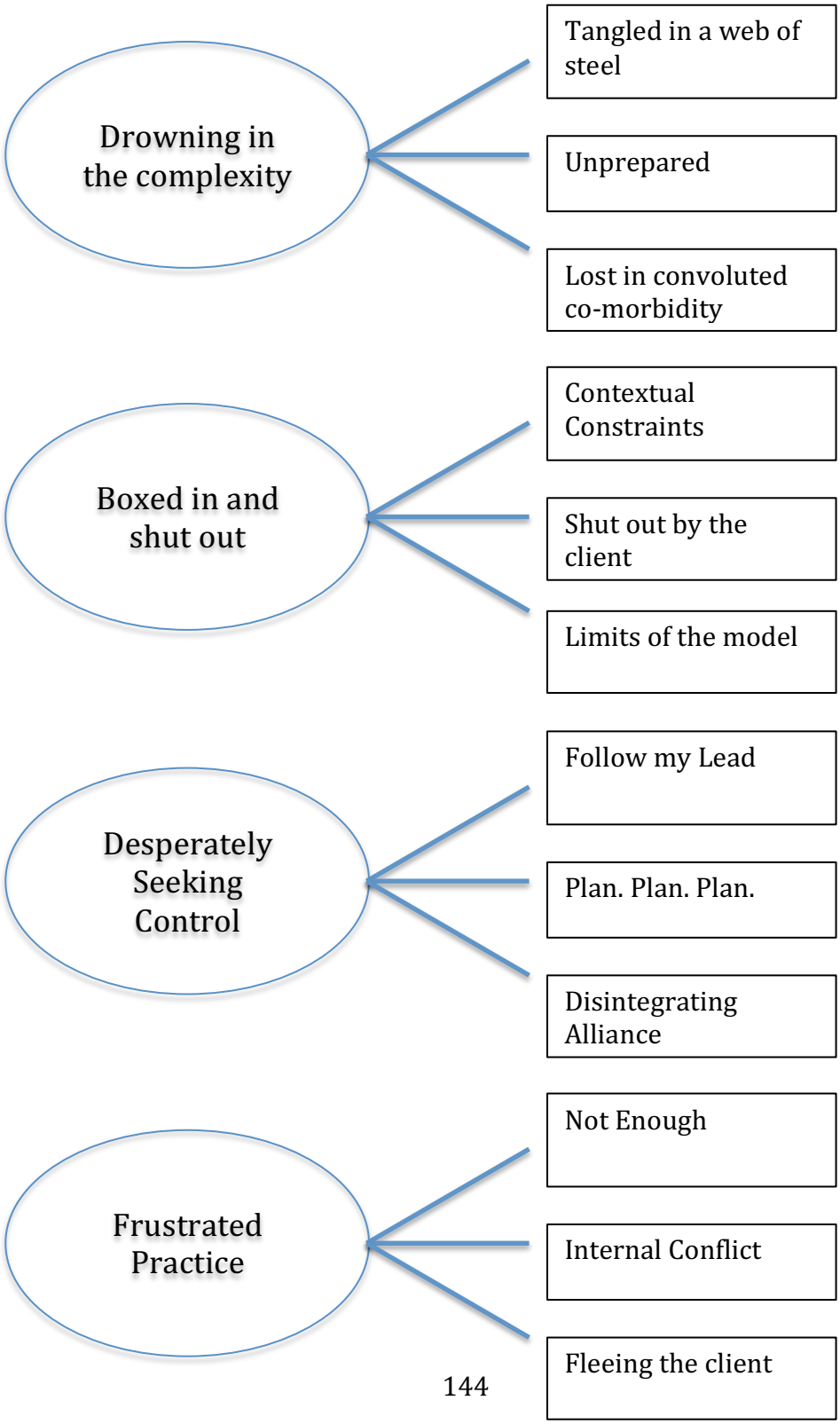
Appendix 10.4: Initial Thematic Map

The initially identified twelve potential high-order themes were collapsed into four themes with relevant subthemes, which can be seen in Thematic Map 1 below.



Appendix 10.5: Final Thematic Map

The four themes in Thematic Map one were further reviewed. It was decided that the higher order theme 'Getting Lost' be renamed to 'Drowning in the Complexity' in order to better represent the experiences of the participants. The sub-theme 'Lost in convoluted co-morbidity' was decided to be more homogenous and had better internal consistency with the theme 'Drowing in the Complexity". Lastly, it was agreed that the higher order themes 'Findng a way in' and 'Emotional Impact' should be renamed to "Desperately seeking control' and 'Frustrated practice' in order to better represent and reflect the participants experience.



Appendix 11.1: Reflective Journal Extract Following the Pilot Interview

Having recently completed the pilot interview I have taken some time to reflect on the process and I have discussed the experience with my research supervisor. Conducting the pilot interview proved to be a useful as it allowed me to assess the appropriateness of my interview schedule along with practicing my general interviewing style. Prior to the interview commencing I noticed I was apprehensive, perhaps as a result of my novice research status and being uncertain as to what to expect. On reflection my own apprehension may have led to difficulties with building rapport with the participant in the early stages of the interview, which may have impacted on how comfortable they felt sharing their experiences. Completing this initial interview has allowed me to become more familiar with the procedure associated with conducting a semi-structured interview and I therefore hope in the future that I will feel more confident in creating a rapport with participants and establishing an environment that facilitates the participants being able to share their experiences fully.

During the interview I noticed I was keen to ensure that the interview questions were asked in the exact order that I had documented on my schedule and became somewhat disconcerted when the participant began to talk about areas of their experience that I had intended to question at a later stage. Having listened to the audio of the interview and discussed this issue with my supervisor we agreed that while it is useful to have a schedule of questions as a guide it is also imperative to give space to the participant to discuss their experiences in a natural manner and to allow for the free flowing of the interview. We reflected that this would allow for the participant to feel able to fully explore their experiences in detail rather than potentially being curtailed by having a set order of questions imposed onto them. Furthermore, I hope that reducing how rigidly I adhere to the order of the schedule and instead following the participant's lead will reduce my impact on the overall interview process. This was a useful learning point and I will ensure to build on this interview skill during the remaining scheduled interviews.

Further to the above reflections I noticed that at time during the interview I often felt overwhelmed with the amount of information that the participant shared and I was on occasion unsure as to how to proceed in terms of which points I should follow-up on. On reflection, the specific points I chose to follow-up on may have been influenced by

my own values, beliefs and knowledge of CBT. This may have influenced the data collected and I reflected with my supervisor that it was important to be mindful of this during the remaining interviews and the importance of the need to adopt an open and curious stance at all times during the interview process.

Having read the transcript of the interview, my supervisor and I discussed the need to add in some prompts that could be used to encourage the participant to share the impact of their emotional experience more fully in order that I was able to acquire rich and detailed data that was pertinent to my research question.

Appendix 11.2 Reflective Journal Extract During Data Analysis

Phase Two of Thematic Analysis

Having familiarised myself with the data during stage one of the thematic analysis I have moved onto coding the interview transcripts systematically. At times I have felt overwhelmed with this task due to the amount of data that has been collected. I have noticed that initially I appeared to have established codes that were predominately semantic. Having discussed this with my research supervisor I have begun to develop my ability to establish latent codes in order to go beyond the surface of what the participant has expressed. I was conscious during this process of the impact that my own values and beliefs may have on how I am interpreting the data. The reflective journal that I have kept through out the research process has allowed me to attend to my own opinions that may impact on the developing codes. I noticed how I strongly resonated with the challenges expressed by some participants regarding managing co-morbidity and working within tight timeframes. I am aware that the resonance I had with these particular challenges as a result of my own experiences may limit what I am attending to during the coding process. Furthermore, due to my engagement with the literature regarding the difficulties that can occur in CBT for OCD in terms of adherence to ERP work I am aware that I may be susceptible to only attending to the difficulties associated with delivering ERP to those with OCD and may not be as receptive to the experiences expressed by the participants which do not align with this perspective. I therefore have endeavoured to adopt and open and curious stance during the coding process in order that the positive as well as negative experiences the participants may have had regarding engaging a client in treatment are attended to.

I am daunted by the prospect of moving from a large number of codes to a small set of themes and subthemes. Collating the relevant data extracts for each established code has been a useful process and has allowed me to begin to see how certain codes may be able to be grouped together in order to reach a theme. I anticipate supervision being helpful during stage three of the analysis in which I begin to generate the themes.